DELTA DENTAL®

# PPO Pediatric Plans

## 2-9 Enrolled Employees
## Benefit Summary
## New Jersey

## Pediatric Benefits

| Benefit Type | Basic PPO Pediatric Plan | | Enhanced PPO Pediatric Plan | |
|---|---|---|---|---|
| | Pediatric Benefits <19 (PPO) | Pediatric Benefits <19 (Premier & Out-of-Network*) | Pediatric Benefits <19 (PPO) | Pediatric Benefits <19 (Premier & Out-of-Network*) |
| **Diagnostic & Preventative**<br>• Oral examinations and cleanings<br>• Bitewing x-rays<br>• Sealants (age limits apply)<br>• Topical fluoride (age limits apply)<br>• In-office A1c diabetes testing | 100% | 100% | 100% | 100% |
| **Basic Restorative Services**<br>• Composite (white) fillings | 50% | 50% | 80% | 80% |
| **Endodontics** | 50% | 50% | 50% | 50% |
| **Periodontics** | 50% | 50% | 50% | 50% |
| **Oral Surgery** | 50% | 50% | 50% | 50% |
| **Major Services**<br>• Crowns<br>• Inlays/onlays<br>• Prosthodontics (dentures, bridges, implants)<br>• Denture repairs | 50% | 50% | 50% | 50% |
| **Orthodontics (Medically necessary)** | 50% | 50% | 50% | 50% |
| **Orthodontics (Non-medically necessary)** | Not covered | Not covered | Not covered | Not covered |
| **Deductible** | $135/$405 (Applied to D&P) | $135/$405 (Applied to D&P) | $35/$105 (Not applied to D&P) | $35/$105 (Not applied to D&P) |
| **Maximum Annual Out of Pocket (1 Child)** | $350 | No limit | $350 | No limit |
| **Maximum Annual Out of Pocket (2 or more children)** | $700 | No limit | $700 | No limit |
| **Annual Maximum (per covered person)** | None | None | None | None |
| **Medically Necessary Orthodontics Maximum** | None | None | None | None |
| **Waiting Period** | None | None | None | None |
| **Eligibility Age** | <19 | <19 | <19 | <19 |
| **Network** | Delta Dental PPO | Premier/Out-of-Network | Delta Dental PPO | Premier/Out-of-Network |
| **Out of Network Reimbursement**** | Not Applicable | PPO Fee (MAC Plan) | Not Applicable | PPO Fee (MAC Plan) |

*Applies to services received by non-participating dentists

**Members will be subject to billing for the difference between the PPO Approved Fee and the Participating Dentist Maximum Approved Charge (PMAC). Coverage percent is based on the PPO Schedule of Fees.

COINSURANCE PERCENTAGES REPRESENT THE AMOUNT PAID BY DELTA DENTAL OF NJ
COVERAGE FOR PEDIATRIC EHB BASED ON CDT CODES COVERED BY NJ FAMILY CARE/CHIP PLAN
COVERAGE FOR ADULTS (>19) BASED ON CDT CODES COVERED BY STANDARD DELTAUSA POLICIES

This is a summary of deductible, coinsurance, out-of-pocket limits, and other components of plan design. All coverage provisions, limitations and exclusions can be found in the group contract and certificate of coverage. Some Covered Services for Pediatric Enrollees require that you obtain a Prior Authorization from us before the service is performed. The covered dental services that require Prior Authorization are described in the certificate of coverage. Where Prior Authorization is required but not obtained, Delta Dental can apply a penalty of up to 50% of the charges that would otherwise be covered.

## Need Help?

Visit DeltaDentalNJ.com to find a participating dentist or DeltaDentalNJ.com/MySmile to print your ID card.

For benefits or claims questions, call **800-452-9310**.