DELTA DENTAL®

PPO Plus Premier Pediatric Plans

2-9 Enrolled Employees
Benefit Summary
New Jersey

Pediatric Benefits

Benefit Type	Basic PPO Plus Premier Pediatric Plan		Enhanced PPO Plus Premier Pediatric Plan	
	Pediatric Benefits <19 (PPO & Premier	Pediatric Benefits <19 (Out-of-Network*)	Pediatric Benefits <19 (PPO & Premier	Pediatric Benefits <19 (Out-of-Network*)
Diagnostic & Preventative • Oral examinations and cleanings • Bitewing x-rays • Sealants (age limits apply) • Topical fluoride (age limits apply) • In-office A1c diabetes testing	100%	100%	100%	100%
Basic Restorative Services • 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 • Crowns • Inlays/onlays • Prosthodontics (dentures, bridges, implants) • 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	PPO & Premier	Out-of-Network	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**.