DELTA DENTAL®

PPO 2
Benefit summary for 2-50 lives

Chadler Plan highlights

Benefit Type	Adult Benefits >19 (PPO)	Adult Benefits >19 (Premier & Out-of-Network*)	Enhanced Pediatric PPO Plan <19 (PPO)	Enhanced Pediatric PPO Plan <19 (Premier & Out-of-Network*)
Orthodontics (Medically necessary)	Not Covered	Not Covered	50%	50%
Orthodontics (Non-medically necessary)	Not Covered	Not Covered	Not Covered	Not Covered
Deductible	$25/$75 (not applied to P&D)	$50/$150 (not applied to P&D)	$35/$105 (not applied to P&D)	$35/$105 (not applied to P&D)
Maximum annual out of pocket (1 child)	No Limit	No limit	$350	No limit
Maximum annual out of pocket (2 or more children)	No Limit	No limit	$700	No limit
Annual Maximum (per covered person)	$1,500	$1,500	None	None
Medically Necessary Orthodontics Maximum	None	None	None	None
Waiting period	None	None	None	None
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)

Pediatric Only Benefits	Enhanced Pediatric PPO Plan	
Benefit Type	Pediatric Benefits <19 (PPO)	Pediatric Benefits <19 (Premier & Out-of-Network*)
Preventive and Diagnostic • Oral examinations and cleanings • Bitewing x-rays • Sealants (age limits apply) • Topical fluoride (age limits apply) • In-office A1c diabetes testing	100%	100%
Basic Restorative Services • Composite (white) fillings	80%	80%
Endodontics	50%	50%
Periodontics	50%	50%
Oral Surgery	50%	50%
Major Services • Crowns • Inlays/onlays • Prosthodontics (dentures, bridges, implants) • Denture repairs	50%	50%

*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.

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Gateway Regional Chamber of Commerce

Adult benefits

Preventive & Diagnostic	Frequency	PPO and Premier & Out-of-Network
Oral exams and evaluations Consultations—combined with all other exams Emergency exams—combined with all other exams	2 per calendar year	100%
Cleanings/Prophylaxis	2 per calendar year	
Bitewing X-rays	1 per calendar year	
Full mouth X-rays or panoramic film	1 per 5 years	
Sealants	Not applicable	
Topical fluoride	Not applicable	
Space maintainers	Not applicable	

*Any member covered under this plan that is 19 years of age or older is covered as an Adult.

Basic Services		PPO and Premier & Out-of-Network
Fillings	Repeat restorations of same surface payable once in 2 years	80%
Composite/resin restorations on second bicuspids and molars (white fillings)	Composite resin restorations will be covered on all teeth	80%
Simple extractions	1 per lifetime per tooth	80%
Root canal therapy (Endodontics)	1 per lifetime per tooth	50%
Periodontal maintenance	2 per calendar year. Periodontal maintenance is interchangeable with, but not in addition to, routine cleanings	50%
Periodontal surgeries (gingivectomy, osseous surgery, flap surgery and grafts, etc.)	1 per three years per quadrant. Note: frequencies vary by procedure code.	50%
Oral surgery	Frequencies vary by procedure code. If performed within 6 months of a major restoration or endodontic procedure, no further benefits provided for the extraction.	50%
General anesthesia or IV Sedation	Payable with covered oral surgery	50%

Major Services		PPO and Premier & Out-of-Network
Single crowns	Replacement 1 in 5 years against itself or any other major services on the same tooth.	50%
Stainless steel crowns	Replacement 1 in 2 years	50%
Crown inlay, onlay and veneer repairs	No frequency limitations	50%
Crown recements	Payable 6 months after insertion then 1 in 12 months	50%
Bridgework	1 per 5 years	50%
Full and partial dentures	1 per 5 years	50%
Repair of dentures	Not billable when performed within 6 months of the initial placement by the same dentist/ dental office, but then payable 1 in 6 months	50%
Implants	Once every 60 months per tooth	50%

Illustrative Rates

	Monthly Premium
Employee	$36.95
Employee + 1	$73.88
Employee + 2 or more	$140.39

Pediatric underwriting policies and requirements

- 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.
- 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. There are limitations and exclusions for various services.
- Out-of-pocket costs are likely to be greater when services are provided by a dentist who is not a network dentist because network dentists have agreed to accept lower fee allowances than non-network dentists.
- Some Covered Services for Pediatric Enrollees require that you obtain a Prior Authorization from us before the service is performed.
- The services that require Prior Authorization are described in a 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.

Underwriting policies and requirements

- Proposed rates are guaranteed for 12 months.
- Proposed rates include 5% general agent override and 10% broker commission.
- Proposed rates are based upon a minimum participation of 50% of all eligible employees.
- The benefits outlined above are a summary of the quoted plan design. Full details on the plan of benefits and applicable policy provisions, including limitations and exclusions, are provided in the group contract.
- With the Delta Dental PPO Plus Premier™ program, members utilizing Delta Dental PPO™ or Delta Dental Premier® dentists will enjoy discounted dental fees in addition to protection from balance billing for charges above the dentist's maximum allowable charges. Members utilizing non-participating dentists may be subject to balance billing. Claims for non-participating dentists will be reimbursed at Delta's maximum allowable charges.
- With the Delta Dental PPO program, members utilizing Delta Dental PPO dentists will enjoy discounted dental fees in addition to protection from balance billing for charges above the dentist's maximum allowable charges. Members utilizing non-participating dentists may be subject to balance billing. Claims for non-PPO dentists will be reimbursed using the discounted PPO fee schedule.

Need help?

Visit DeltaDentalNJ.com to find a participating dentist, print your ID card or download our mobile app.

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

DELTA DENTAL®