DELTA DENTAL®

South County Health
Delta Dental PPO Plus Premier™

SOUTH COUNTY HEALTH

The information listed here is not a guarantee of payment. Payment is based on the Delta Dental allowance for each procedure. To be covered, services must be dentally necessary and in accordance with Delta Dental's treatment guidelines. All services must be performed in a dental office. These benefits are listed according to the level of coverage (i.e. 100%, 80%). Your group number is 7223.

Calendar Year Maximum:
Plan A: $1,250
Plan B: $1,000

Annual Deductible:
Plan A: $0
Plan B: $50 Individual / $150 Family

Orthodontic Lifetime Maximum
Plan A: $1,000
Plan B: N/A

P Pre-treatment Estimate recommended

D Deductible applies

Procedure	Plan A	Plan B	Frequency / Limitations
Diagnostic			
Oral Exam	100%	100%	Twice per calendar year performed by a general dentist
Bitewing x-rays	100%	100%	Two sets per calendar year
Complete x-ray series or panoramic film	100%	100%	Once every 36 months
Single x-rays	100%	100%	As required
Preventive			
Cleanings	100%	100%	Twice per calendar year. More frequent cleanings may be allowed for pregnant women or patients with diabetes or compromised immune systems. Documentation is required.
Fluoride treatment	100%	100%	For children under age 19, twice per calendar year
Sealants	100%	100%	For children under age 18, once every 24 months on unrestored permanent molars.
Space Maintainers	100%	80%	Unilateral once per lifetime for lost deciduous (baby) teeth Bilateral once every 60 months for lost deciduous (baby) teeth
Minor Restorative			
Fillings	100%	80% D	Amalgam (silver) fillings and composite (white) fillings
Simple extractions	100%	100% D	Not requiring surgery
Repairs to existing partial or complete dentures	100%	80% D	Once per calendar year
Recementing crowns or bridges	100%	80% D	Once every 36 months
Rebasing or relining of partial or complete dentures	100%	80% D	Once every 60 months
Major Restorative			
P Crowns over natural teeth, build ups, posts & cores	100%	55% D	Replacement limited to once every 60 months
Endodontics			
Root canal therapy on permanent front teeth	100%	100% D	One procedure per tooth per lifetime.
Root canal therapy on molars and bicuspids	100%	80% D	One procedure per tooth per lifetime.
Periodontics			
Periodontal maintenance following active therapy	50%	50% D	Two per calendar year
P Root planing and scaling	50%	50% D	Once per quadrant every 36 months
P Osseous (bone) surgery	50%	50% D	Once per quadrant every 36 months (bone grafts are not covered)
P Gingivectomies	50%	50% D	Once per site every 36 months
P Soft tissue grafts	50%	50% D	Once per site every 36 months
P Crown lengthening	50%	50% D	Once per site every 36 months
Prosthodontics			
P Bridges and crowns over implants	50%	N/A	Replacement limited to once every 60 months
P Partial and complete dentures	50%	N/A	Replacement limited to once every 60 months
Extractions and Oral Surgery			
Surgical extractions and other routine oral surgery	100%	80% D	When not covered by a patient's medical plan
P Surgical placement of endosteal implant and abutment	50%	N/A	Once per tooth site per lifetime
Orthodontics			
P Elective braces and related services	50%	N/A	For all covered members. Subject to a lifetime maximum. No pre-approval required.
Other Services			
Palliative treatment (minor procedures necessary to relieve acute pain)	100%	100% D	Twice per calendar year
General anesthesia or intravenous (I.V.) sedation for certain complex medical procedures	100%	80% D	

Dependent coverage: Dependent children are covered up until the end of the year that they turn age 26.

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This is a summary of benefits. The information shown here is not a guarantee of payment. Refer to the Summary Plan Description (SPD) for the full plan terms. The SPD includes any limitations or exclusions not seen here. To be covered, services must be dentally necessary and appropriate as per our review guidelines.

Time limits on services (e.g. 6, 12, 24, 36, or 60 months) are figured to the exact day. Services are then covered the following day. For example, when a service is covered once every 12 months, if the service was done on July 1, it will not be covered again until the following year on July 2 or after.

Unless specifically covered by your dental plan, the following are not covered:

- Sevices that are not dentally necessary and appropriate according to our review guidelines. Services subject to these guidelines include, but are not limited to, root canals; crowns and related services; bridges; periodontal services; orthodontics; and oral surgery. We will make a decision whether a service is dentally necessary based on these guidelines. A service may not be covered under these guidelines even if it was recommended by a dentist. Our guidelines can be found on our website at **deltadentalri.com**. You can have your dentist send us a request for a pre-treatment estimate in advance of the service to see if the service meets our guidelines.
- Services greater than the annual maximum.
- Services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group.
- An illness or injury that Delta Dental decides is employment-related.
- Services you would not have to pay for if you did not have this Delta Dental coverage.
- Services or supplies that are experimental in terms of generally accepted dental standards.
- Services done by a dentist who is a member of your immediate family.
- An illness, injury or dental condition for which benefits are, or would have been available, through a government program if you did not have this Delta Dental coverage.
- Services done by someone who is not a licensed dentist or a licensed hygienist working as authorized by applicable law.
- Disorders related to the temporomandibular joints (TMJ), including occlusal orthotic device and surgery.
- Services to increase the height of teeth or restore occlusion.
- Restorations needed because of teeth grinding or due to erosion, abrasion or attrition.
- Services done mainly to change or to improve your appearance.
- Splinting and other services to stabilize teeth.
- Laboratory or bacteriological tests or reports.
- Temporary, complete dentures or temporary, fixed bridges or crowns.
- Prescription drugs.
- General anesthesia or intravenous sedation for non-surgical extractions, diagnostic, preventive, or minor restorative services.
- General anesthesia or intravenous sedation given by anyone other than a dentist.

Delta Dental can adopt and apply policies that we deem reasonable when we approve the eligibility of subscribers and the appropriateness of treatment plans and related charges.

All claims must be filed within one year of the date of service.

NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY POLICY
Delta Dental of Rhode Island does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-843-3582.
Português (Portuguese): ATENÇÃO: Se fala português, encontramse disponíveis serviços linguísticos, grátis. Ligue para 1-800-843-3582.

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