

Delta Dental Premier® for Small Businesses - Standard Plan

Legend & Icons		PROCEDURE		UNDER AGE 19	AGE 19 & OVER	FREQUENCY / LIMITATIONS*
P Pre-treatment Estimate Recommended A Prior Authorization Required D Deductible Applies		DIAGNOSTIC				
		Oral exam		100%	100%	Twice per calendar year
		Bitewing x-rays		100%	100%	Under age 19 limitations: Two sets per calendar year Age 19 & over limitations: One set per calendar year
		Complete x-ray series or panoramic film		100%	100%	Once every 60 months
		Single x-rays		100%	100%	As required
		PREVENTIVE				
		Cleaning		100%	100%	Twice per calendar year
		Fluoride treatment		100%	Not Covered	Twice per calendar year
		Sealants		100%	Not Covered	Once every 24 months on unrestored permanent molars
		Space maintainers		100%	Not Covered	Unilateral space maintainers once per lifetime for lost deciduous (baby) teeth Bilateral space maintainers once every 60 months for lost deciduous (baby) teeth
		RESTORATIVE				
		Amalgam (silver) fillings and composite (white) fillings		75% D	75%	
		P Crowns, build ups, posts and cores		50% D	Not Covered	Covered over natural teeth when teeth cannot be restored with regular fillings Replacement limited to once every 60 months
		Recementing crowns or bridges		75% D	75%	Once every 60 months
		ENDODONTICS				
		Root canal therapy		75% D	75%	

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

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, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-843-3582.

See reverse side for more information.

Legend & Icons
Pre-treatment Estimate Recommended
Prior Authorization Required
Deductible Applies

Beyond Benefits
When you visit us at deltadentalri.com , you can access a wealth of important dental health information and manage your plan by:
• Checking your benefits and claims • Reviewing your deductibles and maximums • Using our Find A Dentist tool to find a dentist in your area

Out-of-Network Coverage
You have the freedom to choose any dentist, but it is important to know that your out-of-pocket costs may be higher when you visit a dentist who does not participate in our network. Non-participating dentists have not agreed to accept the Delta Dental allowance as payment in full, so services from an out-of-network dentist may cost you more. You may also have to pay the dentist at the time of service and file a claim yourself. In Rhode Island, nine out of 10 dentists participate with us. To find a participating dentist near you, use our Find A Dentist tool at www.deltadentalri.com

Note: This plan does not include a missing tooth clause. In addition, crowns, bridges, partials and complete dentures are paid when the permanent structure is inserted (seated) by the dentist. Member coverage must be active on the date that the permanent structure is inserted and payment is based on benefits available on that day — for example, if the member's annual maximum has been paid prior to the insertion of the permanent structure, the service will not be paid.

* 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.

PROCEDURE	UNDER AGE 19	AGE 19 & OVER	FREQUENCY / LIMITATIONS*
PERIODONTICS			
Root planing and scaling	50%	Not Covered	Once per quadrant every 24 months
Osseous (bone) surgery	50%	Not Covered	Once per quadrant every 36 months (bone grafts are not covered)
Gingivectomies	50%	Not Covered	Once per site every 36 months
Soft tissue grafts	50%	Not Covered	Once per site every 60 months
Crown lengthening	50%	Not Covered	Once per site every 60 months
Periodontal maintenance following active therapy	50%	Not Covered	Twice per calendar year
PROSTHODONTICS			
Bridges and crowns over implants	50%	Not Covered	Replacement limited to once every 60 months
Partial and complete dentures	50%	Not Covered	Replacement limited to once every 60 months
Repairs to existing partial or complete dentures	75%	75%	Once per calendar year
Rebasing or relining of partial or complete dentures	75%	75%	Once every 60 months
IMPLANT SERVICES			
Surgical placement of endosteal implant and abutment	50%	Not Covered	Once per tooth site per lifetime
EXTRACTIONS AND ORAL SURGERY			
Extractions and other routine oral surgery when not covered by a patient's medical plan	75%	75%	
ORTHODONTICS			
Medically necessary braces and related services	50%	Not Covered	Requires prior authorization. No payment will be made if not obtained. Covered only when medically necessary. Patient must have severe and handicapping malocclusion as defined by our guidelines. Once per lifetime
OTHER SERVICES			
Palliative treatment (minor procedures necessary to relieve acute pain)	75%	75%	Twice per calendar year
General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures	75%	75%	
Occlusal guards	50%	Not Covered	Once every 12 months. Not covered when used as an athletic mouth guard