DELTA DENTAL®

# Benefit Highlights

**TOWN OF HOPKINTON**

**Product Name:** Delta Dental Premier
**Plan Type:** National Coverage

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 **5885-0102**. **Coverage for benefits with time limitations (i.e. 6,12,24,36 or 60 months) is calculated to the exact day.**

| | |
|---|---|
| **The annual maximum is:** | $1,200.00 per member per calendar year |
| **The annual deductible is:** | $0.00 |
| **The maximum lifetime cap:** | Unlimited |

**Pretreatment estimates are recommended for underlined procedures.**

**Plan pays 100%; Member Coinsurance 0%**

- Oral exam - once per calendar year performed by a general dentist
- Cleaning - twice per calendar year
- Fluoride treatment - for children under age 19 once per calendar year
- Bitewing x-rays - one set per calendar year
- Complete x-ray series or panoramic film once every 36 months
- Single x-rays as required
- Palliative treatment (minor procedures necessary to relieve acute pain) twice per calendar year
- Amalgam (silver) fillings. Composite (white) fillings on front teeth only. For composite fillings on back teeth, the plan pays up to what would have been paid for an amalgam filling. Patient is responsible for the balance up to the dentist's charge.
- Space maintainers once every 60 months for lost deciduous (baby) teeth
- Extractions and other routine oral surgery when not covered by a patient's medical plan
- General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures
- Root canal therapy on permanent teeth - one procedure per tooth per lifetime. Vital pulpotomy and apicoectomies also covered once per tooth per lifetime.
- Repairs to existing partial or complete dentures once per calendar year
- Recementing crowns or bridges once every 60 months
- Rebasing or relining of partial or complete dentures once every 60 months
- Crowns over natural teeth, build ups, posts and cores - replacement limited to once every 60 months

**Plan pays 50%; Member Coinsurance 50%**

- Periodontal maintenance following active therapy - two per year
- Bridges and crowns over implants - replacement limited to once every 60 months
- Partial and complete dentures - replacement limited to once every 60 months
- Root planing and scaling once per quadrant every 24 months.
- Osseous (bone) surgery once per quadrant every 36 months (bone grafts are not covered).
- Gingivectomies once per site every 36 months.
- Soft tissue grafts once per site every 60 months
- Crown lengthening once per site every 60 months

**Orthodontics:**
**Plan pays 50%; Member Coinsurance 50%**

- Elective braces and related services for dependent children under the age of 19. Subject to a lifetime maximum. No pre-approval required.

**Lifetime maximum (orthodontics only) is $1,200.00**

**Dependent coverage -** Dependent children are covered up until the end of the year that they turn age 19. Dependent children who are full-time students over age 19 are covered as long as they stay in school or up until the end of the year that they turn age 25.

DELTA DENTAL®

# Exclusions & Limitations

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

- Services that do not qualify for payment according to our dental treatment guidelines. (These guidelines assist Delta Dental in making determinations as to whether services are covered and whether a particular service is the least costly, clinically acceptable method of prevention, diagnosis or treatment. A service may not qualify for coverage under these guidelines even though it was performed or recommended by a dentist.)
- Any services that are not specifically covered in your group's Certificate of Coverage.
- Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trustee or similar person or group.
- An illness or injury that Delta Dental determines is employment related.
- Services you would not be required to pay for if you did not have this Delta Dental coverage.
- Services provided 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 rendered by someone other than a licensed dentist or a licensed hygienist operating as authorized by applicable law.
- Specialty exams.
- Consultations.
- Disorders related to the temporomandibular joint (TMJ), including night guards and surgery.
- Services to increase the height of teeth or restore occlusion.
- Restorations required because of erosion, abrasion or attrition.
- Services meant primarily to change or improve your appearance.
- Occlusal guards.
- Implants.
- Bone grafts.
- Splinting and other services to stabilize teeth.
- Prescription drugs, lab exams or reports.
- Guided tissue regeneration.
- Temporary bridges or crowns.
- Services related to congenital abnormalities.
- General anesthesia/intravenous sedation for nonsurgical extractions, diagnostic, preventive or any restorative services.
- General anesthesia/intravenous sedation administered by anyone other than a dentist.

Delta Dental also reserves the right to adopt and to apply, from time to time, such administrative policies as it deems reasonable in approving 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.