DELTA DENTAL®

Small Business Plans

Groups with 10-50 employees

NEW JERSEY — 2020

Delta Dental PPO™

Why choose Delta Dental[1]? It's simple, really.

Employees are a small business owner's greatest investment, and it's difficult to balance protecting employee health and managing a budget. That's why we've specially designed a portfolio of dental plans[2] to help small businesses meet their benefits goals — simply. We deliver valuable dental benefits at affordable rates, we eliminate complicated benefit administration and we cover more than the bare minimum with rich plan designs and optional features.

The Delta Dental Difference®

Our Small Business Program offers rate stability.

We work hard to keep rates consistent year after year.

Our rates don't include hidden fees or set-up charges, so clients know what to expect from enrollment to claims processing.

We specialize in dental benefits. Our rates reflect the true cost of the plan — no cost shifting to other lines of coverage.

We design our portfolio of plans to fit any budget.

We offer the power of choice — contribution, network participation, orthodontics and optional features to suit any benefits strategy.

Plan options, such as PPO plus Premier or voluntary coverage, are attractive for employers and employees alike.

Our plans are easy to use and designed to fit any budget — employers can offer quality dental benefits at an affordable cost.

We keep it simple — from claims to customer service.

Our industry-leading[3] dentist networks make it easy to find network savings.

Our enrollee Online Services offer self-service tools that can answer questions, so small business owners don't have to.

We have dedicated customer service lines, with live representatives to assist enrollees.

We are fast and accurate. Our dental-specific IT platforms process claims with more than 99% accuracy.[4]

For more information, or to get a client quote, contact Small Group Market Sales, (833) 893-3630. Go ahead — crunch some numbers!

[1] Delta Dental of New Jersey, Inc., Delta Dental of Connecticut, and its affiliated companies, which are members, or affiliates of members, of the Delta Dental Plans Association.

[2] In Connecticut, Delta Dental insured plans are underwritten by Delta Dental of Connecticut

[3] NetMinder Dental Network Trend Report, March 2018

[4] Delta Dental 2017 Annual Report

Smiles: A new return on investment

If employees are a small business owner's greatest investment, protecting their smiles could be good for business, since good dental health could mean less expensive dentist visits and missed time at work.[1] But we don't stop at healthy — we've got small businesses covered with key plan features that also make employees happy, which could help in attracting top talent.

Stand-out features and options[2]

Delta Dental PPO
Our open network plans, including our EHB PPO plans, combine access with affordability — enrollees can visit any licensed dentist, but usually save the most when visiting a PPO dentist. And, our plans also include attractive benefits like implant coverage and white fillings, plus options and features, like:

Flexible Plans
We offer small groups options to choose from — like orthodontic coverage and various calendar year deductibles and maximums — to help select a benefits package for every objective.

PPO plus Premier
This feature provides additional cost protections with our Delta Dental Premier® network. Protections include reduced out of pocket expenses because of the larger network, no unbundling of services or billing above the contracted fee. Enrollees shall have the option to access our lowest cost PPO dentists.

[1] Adult Oral Health Survey, Delta Dental Plans Association, January 2017.

[2] Features and options listed may vary by plan. Please contact your general agent or Delta Dental sales representative for complete information.

Delta Dental PPO benefit designs[1]

Open network plans combine savings with access to dentists where enrollees need them.

Employer-paid plans (employer contributes at least 50% of the cost of the plan.)

Group size	10–50 enrolled employees					
Plan	PPO 1 P&D Only		PPO 2		PPO 3	
Coinsurance for	PPO	Premier & Out-of-Network	PPO	Premier & Out-of-Network	PPO	Premier & Out-of-Network
Diagnostic and Preventive (D&P) Services (additional cleaning during pregnancy)	100%		100%		100%	
Basic Services	Not covered		80%		80%	
Major Services (including implants)	Not covered		Not covered		50%	
Endodontics and Periodontics	Not covered		80%		80%	
Oral Surgery	Not covered		80%		80%	
Orthodontics (Children to age 19)	Not covered		Not covered		Not covered	
Orthodontic Lifetime Maximum	Not applicable		Not applicable		Not applicable	
Calendar Year Deductible (per enrollee/per family)	$0		$50/$150		$50/$150	
Deductible Waived for D&P	Yes		Yes		Yes	
Calendar Year Maximum (per enrollee)	Choice: A - $500 B - $750		Choice: A - $1,000 B - $1,250		Choice: A - $1,500 B - $2,000 C - $5,000	
Fee Basis	PPO[2]		PPO[2]		PPO[2]	
Waiting Periods	None		None		None	
Rate Tier	3 tier		3 tier		3 tier	

[1] This benefit information is only a summary and not intended or designed to replace or serve as the plan contract. Please contact your general agent or Delta Dental sales representative for complete information.

[2] Reimbursement for all dentists is based on the PPO contracted fee.

Delta Dental PPO benefit designs[1]

Open network plans combine savings with access to dentists where enrollees need them.

Employer-paid plans (employer contributes at least 50% of the cost of the plan.)

Group size	10–50 enrolled employees					
Plan	PPO 4		PPO 5		PPO 6	
Coinsurance for	PPO	Premier & Out-of-Network	PPO	Premier & Out-of-Network	PPO	Premier & Out-of-Network
Diagnostic and Preventive (D&P) Services (additional cleaning during pregnancy)	100%		100%		100%	
Basic Services	80%		100%		100%	
Major Services (including implants)	50%		60%		60%	
Endodontics and Periodontics	80%		100%		100%	
Oral Surgery	80%		100%		100%	
Orthodontics (Children to age 19)	50%		Not covered		50%	
Orthodontic Lifetime Maximum	$1,000		Not applicable		$1,000	
Calendar Year Deductible (per enrollee/per family)	$50/$150		A: $50/$150 or B: $75/$225		A: $50/$150 or B: $75/$225	
Deductible Waived for D&P	Yes		Yes		Yes	
Calendar Year Maximum (per enrollee)	Choice: A - $1,500 B - $2,000		Choice: A - $1,500 B - $2,000 C - $5,000		Choice: A - $1,500 B - $2,000	
Fee Basis	PPO[2]		PPO[2]		PPO[2]	
Waiting Periods	None		None		None	
Rate Tier	3 tier		3 tier		3 tier	

[1] This benefit information is only a summary and not intended or designed to replace or serve as the plan contract. Please contact your general agent or Delta Dental sales representative for complete information.

[2] Reimbursement for all dentists is based on the PPO contracted fee.

Delta Dental PPO benefit designs[1]

Open network plans combine savings with access to dentists where enrollees need them.

Benefits differ for PPO versus Premier & Out-of-Network Dentists.

Employer-paid plans (employer contributes at least 50% of the cost of the plan.)

Group size	10–50 enrolled employees							
Plan	PPO A		PPO B		PPO C		PPO D	
Coinsurance for	PPO	Premier & Out-of-Network	PPO	Premier & Out-of-Network	PPO	Premier & Out-of-Network	PPO	Premier & Out-of-Network
Diagnostic and Preventive (D&P) Services (additional cleaning during pregnancy)	100%	80%	100%	80%	100%	100%	100%	100%
Basic Services	80%	60%	80%	60%	100%	80%	100%	80%
Major Services (including implants)	50%	50%	50%	50%	60%	50%	60%	50%
Endodontics and Periodontics	80%	60%	80%	60%	100%	80%	100%	80%
Oral Surgery	80%	60%	80%	60%	100%	80%	100%	80%
Orthodontics (Children to age 19)	Not covered		50%	50%	Not covered		50%	50%
Orthodontic Lifetime Maximum	Not applicable		$1,000		Not applicable		$1,000	
Calendar Year Deductible (per enrollee/per family)	$50/$150	$75/$225	$50/$150	$75/$225	$50/$150	$75/$225	$50/$150	$75/$225
Deductible Waived for D&P	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Calendar Year Maximum (per enrollee)	Choice: A - $1,500/$1,000 B - $2,000/$1,500 C - $3,000/$2,500		Choice: A - $1,500/$1,000 B - $2,000/$1,500 C - $3,000/$2,500		Choice: A - $2,000 B - $2,500		Choice: A - $2,000 B - $2,500	
Fee Basis	PPO[2]		PPO[2]		PPO[2]		PPO[2]	
Waiting Period	None		None		None		None	
Rate Tier	3 tier		3 tier		3 tier		3 tier	

[1] This benefit information is only a summary and not intended or designed to replace or serve as the plan contract. Please contact your general agent or Delta Dental sales representative for complete information.

[2] Reimbursement for all dentists is based on the PPO contracted fee.

Delta Dental PPO plus Premier benefit designs[1]

Open network plans combine savings with access to dentists where enrollees need them.

Benefits differ for PPO versus Premier & Out-of-Network Dentists.

Employer-paid plans (employer contributes at least 50% of the cost of the plan.)

Group size	10–50 enrolled employees					
Plan	PPO Plus Premier 1 P&D Only		PPO Plus Premier 2		PPO Plus Premier 3	
Coinsurance for	PPO	Premier & Out-of-Network	PPO	Premier & Out-of-Network	PPO	Premier & Out-of-Network
Diagnostic and Preventive (D&P) Services (additional cleaning during pregnancy)	100%		100%		100%	
Basic Services	Not covered		80%		80%	
Major Services (including implants)	Not covered		Not covered		50%	
Endodontics and Periodontics	Not covered		80%		80%	
Oral Surgery	Not covered		80%		80%	
Orthodontics (Children to age 19)	Not covered		Not covered		Not covered	
Orthodontic Lifetime Maximum	Not applicable		Not applicable		Not applicable	
Calendar Year Deductible (per enrollee/per family)	$0		$50/$150		$50/$150	
Deductible Waived for D&P	Yes		Yes		Yes	
Calendar Year Maximum[2] (per enrollee)	Choice: A - $750/$500 B - $1,000/$750		Choice: A - $1,000/$750 B - $1,250/$1,000		Choice: A - $2,000/$1,500 B - $3,000/$2,500 C - $5,000/$4,500	
Fee Basis	PPO Plus Premier[3]		PPO Plus Premier[3]		PPO Plus Premier[3]	
Waiting Period	None		None		None	
Rate Tier	3 tier		3 tier		3 tier	

[1] This benefit information is only a summary and not intended or designed to replace or serve as the plan contract. Please contact your general agent or Delta Dental sales representative for complete information.

[2] Calendar year maximum is a single combined maximum amount; in – and out-of-network services do not accrue separately. The calendar year maximum will be higher for enrollees who visit a PPO provider.

[3] Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists, and the plan contract allowance for non-Delta Dental dentists.

Delta Dental PPO plus Premier benefit designs[1]

Open network plans combine savings with access to dentists where enrollees need them.

Benefits differ for PPO versus Premier & Out-of-Network Dentists.

Employer-paid plans (employer contributes at least 50% of the cost of the plan.)

Group size	10–50 enrolled employees					
Plan	PPO Plus Premier 4		PPO Plus Premier 5		PPO Plus Premier 6	
Coinsurance for	PPO	Premier & Out-of-Network	PPO	Premier & Out-of-Network	PPO	Premier & Out-of-Network
Diagnostic and Preventive (D&P) Services (additional cleaning during pregnancy)	100%		100%		100%	
Basic Services	80%		100%		100%	
Major Services (including implants)	50%		60%		60%	
Endodontics and Periodontics	80%		100%		100%	
Oral Surgery	80%		100%		100%	
Orthodontics (Children to age 19)	50%		Not covered		50%	
Orthodontic Lifetime Maximum	$1,000		Not applicable		$1,000	
Calendar Year Deductible (per enrollee/per family)	$50/$150		A: $50/$150 or B: $75/$225		A: $50/$150 or B: $75/$225	
Deductible Waived for D&P	Yes		Yes		Yes	
Calendar Year Maximum[2] (per enrollee)	Choice: A - $2,000/$1,500 B - $3,000/$2,500		Choice: A - $1,500/$1,000 B - $2,000/$1,500 C - $5,000/$4,500		Choice: A - $1,500/$1,000 B - $2,000/$1,500	
Fee Basis	PPO Plus Premier[3]		PPO Plus Premier[3]		PPO Plus Premier[3]	
Waiting Period	None		None		None	
Rate Tier	3 tier		3 tier		3 tier	

[1] This benefit information is only a summary and not intended or designed to replace or serve as the plan contract. Please contact your general agent or Delta Dental sales representative for complete information.

[2] Calendar year maximum is a single combined maximum amount; in – and out-of-network services do not accrue separately. The calendar year maximum will be higher for enrollees who visit a PPO provider.

[3] Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists, and the plan contract allowance for non-Delta Dental dentists.

Delta Dental PPO plus Premier benefit designs[1]

Open network plans combine savings with access to dentists where enrollees need them.

Benefits differ for PPO versus Premier & Out-of-Network Dentists.

Employer-paid plans (employer contributes at least 50% of the cost of the plan.)

Group size	10–50 enrolled employees							
Plan	PPO Plus Premier A		PPO Plus Premier B		PPO Plus Premier C		PPO Plus Premier D	
Coinsurance for	PPO	Premier & Out-of-Network	PPO	Premier & Out-of-Network	PPO	Premier & Out-of-Network	PPO	Premier & Out-of-Network
Diagnostic and Preventive (D&P) Services (additional cleaning during pregnancy)	100%	80%	100%	80%	100%	100%	100%	100%
Basic Services	80%	60%	80%	60%	100%	80%	100%	80%
Major Services (including implants)	50%	50%	50%	50%	60%	50%	60%	50%
Endodontics and Periodontics	80%	60%	80%	60%	100%	80%	100%	80%
Oral Surgery	80%	60%	80%	60%	100%	80%	100%	80%
Orthodontics (Children to age 19)	Not covered		50%	50%	Not covered		50%	50%
Orthodontic Lifetime Maximum	Not applicable		$1,000		Not applicable		$1,000	
Calendar Year Deductible (per enrollee/per family)	$50/$150	$75/$225	$50/$150	$75/$225	$50/$150	$75/$225	$50/$150	$75/$225
Deductible Waived for D&P	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Calendar Year Maximum[2] (per enrollee)	Choice: A - $1,500/$1,000 B - $2,000/$1,500 C - $3,000/$2,500		Choice: A - $1,500/$1,000 B - $2,000/$1,500 C - $3,000/$2,500		Choice: A - $1,500/$1,000 B - $2,000/$1,500 C - $2,500/$2,000		Choice: A - $1,500/$1,000 B - $2,000/$1,500 C - $2,500/$2,000	
Fee Basis	PPO Plus Premier[3]		PPO Plus Premier[3]		PPO Plus Premier[3]		PPO Plus Premier[3]	
Waiting Period	None		None		None		None	
Rate Tier	3 tier		3 tier		3 tier		3 tier	

[1] This benefit information is only a summary and not intended or designed to replace or serve as the plan contract. Please contact your general agent or Delta Dental sales representative for complete information.

[2] Calendar year maximum is a single combined maximum amount; in – and out-of-network services do not accrue separately. The calendar year maximum will be higher for enrollees who visit a PPO provider.

[3] Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists, and the plan contract allowance for non-Delta Dental dentists.

Delta Dental PPO and PPO plus Premier benefit designs[1]

Open network plans combine savings with access to dentists where enrollees need them.

Voluntary plans (employer contributes less than 50% of the cost of the plan)

Group size	10–50 enrolled employees							
Plan	PPO V1 P&D Only		PPO V2		PPO Plus Premier V1 P&D Only		PPO Plus Premier V2	
Coinsurance for	PPO	Premier & Out-of-Network	PPO	Premier & Out-of-Network	PPO	Premier & Out-of-Network	PPO	Premier & Out-of-Network
Diagnostic and Preventive (D&P) Services (additional cleaning during pregnancy)	100%		100%		100%		100%	
Basic Services	Not covered		80%		Not covered		80%	
Major Services[2] (including implants)	Not covered		50%		Not covered		50%	
Endodontics and Periodontics[3]	Not covered		80%		Not covered		80%	
Oral Surgery[3]	Not covered		80%		Not covered		80%	
Orthodontics (Children to age 19)	Not covered		Optional (see below)		Not covered		Not covered	
Calendar Year Deductible (per enrollee/per family)	$0		$50/$150		$0		$50/$150	
Deductible Waived for D&P?	Not applicable		Yes		Not applicable		Yes	
Calendar Year Maximum[4] (per enrollee)	Choice: A - $500 B - $750		Choice: A - $1,000 B - $1,500 C - $2,000 (option to remove waiting period, for choice C only)[7]		Choice: A - $500 B - $750		Choice: A - $1,500/$1,000 B - $2,000/$1,500 (option to remove waiting period, for choice B only)	
Fee Basis	PPO[5]		PPO[5]		PPO Plus Premier[6]		PPO Plus Premier[6]	
Waiting Period	None		12 months[2], 6 months[3] (option to remove the waiting period for the $2,000 maximum plan)		None		12 months[2], 6 months[3] (option to remove the waiting period for the $2,000/$1,500 maximum plan)	
Rate Tiers	3 tier		3 tier		3 tier		3 tier	
In addition to the benefits above, Orthodontics Option only available with $2,000 calendar year maximum and waiting period included								
Orthodontics (Children to age 19)	Not covered		50%		Not covered		Not covered	
Orthodontic Lifetime Maximum	Not applicable		$1,000		Not applicable		Not applicable	

[1] This benefit information is only a summary and not intended or designed to replace or serve as the plan contract. Please contact your general agent or Delta Dental sales representative for complete information.

[2] There is a 12-month waiting period for all major services, if covered. The waiting period may be waived for groups with proof of prior comprehensive group dental coverage with no break in coverage.

[3] There is a six-month waiting period for all oral surgery, endodontic and periodontic services. The waiting period may be waived for groups with proof of prior comprehensive group dental coverage with no break in coverage.

[4] Calendar year maximum is a single combined dollar amount; in- and out-of-network services will not accrue separately. The calendar year maximum will be higher for enrollees who visit an in-network provider.

[5] Reimbursement for all dentists is based on the PPO contracted fee.

[6] Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists, and the plan contract allowance for non-Delta Dental dentists.

[7] The waiting period cannot be removed when Orthodontic benefits are selected.

EHB Basic Family PPO I

2-50 Enrolled Employees
Benefit Summary
New Jersey

Pediatric and Adult Benefits

Benefit Type	Adult Benefits >19 (PPO)	Adult Benefits >19 (Premier & Out-of-Network*)	Pediatric Benefits <19 (PPO)	Pediatric Benefits <19 (Premier & 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	60%	60%	50%	50%
Endodontics	Not covered	Not covered	50%	50%
Periodontics	Not covered	Not covered	50%	50%
Oral Surgery	Not covered	Not covered	50%	50%
Major Services • Crowns • Inlays/onlays • Prosthodontics (dentures, bridges, implants) • Denture repairs	Not covered	Not covered	50%	50%
Orthodontics (Medically necessary)	Not covered	Not covered	50%	50%
Orthodontics (Non-medically necessary)	Not covered	Not covered	Not covered	Not covered
Deductible	$75/$225 (Not applied to D&P)	$100/$300 (Not applied to D&P)	$135/$405 (Applied to D&P)	$135/$405 (Applied to D&P)
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)	$1,000	$750	None	None
Medically Necessary Orthodontics Maximum	Not covered	Not covered	None	None
Waiting Period	None	None	None	None
Eligibility Age	>19	>19	<19	<19
Network	Delta Dental PPO	Premier/Out-of-Network	Delta Dental 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.

EHB Basic Family PPO II

2-50 Enrolled Employees
Benefit Summary
New Jersey

Pediatric and Adult Benefits

Benefit Type	Adult Benefits >19 (PPO)	Adult Benefits >19 (Premier & Out-of-Network*)	Pediatric Benefits <19 (PPO)	Pediatric Benefits <19 (Premier & 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	60%	60%	50%	50%
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)	Not covered	Not covered	50%	50%
Orthodontics (Non-medically necessary)	Not covered	Not covered	Not covered	Not covered
Deductible	$75/$225 (Not applied to D&P)	$50/$150 (Not applied to D&P)	$135/$405 (Applied to D&P)	$135/$405 (Applied to D&P)
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)	$1,000	$750	None	None
Medically Necessary Orthodontics Maximum	Not covered	Not covered	None	None
Waiting Period	None	None	None	None
Eligibility Age	>19	>19	<19	<19
Network	Delta Dental PPO	Premier/Out-of-Network	Delta Dental 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.

EHB Enhanced Family PPO III

2-50 Enrolled Employees
Benefit Summary
New Jersey

Pediatric and Adult Benefits

Benefit Type	Adult Benefits >19 (PPO)	Adult Benefits >19 (Premier & Out-of-Network*)	Pediatric Benefits <19 (PPO)	Pediatric Benefits <19 (Premier & 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	80%	80%	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)	Not covered	Not covered	50%	50%
Orthodontics (Non-medically necessary)	Not covered	Not covered	Not covered	Not covered
Deductible	$25/$75 (Not applied to D&P)	$50/$150 (Not applied to D&P)	$35/$105 (Applied to D&P)	$35/$105 (Applied to D&P)
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)	$1,000	$750	None	None
Medically Necessary Orthodontics Maximum	Not covered	Not covered	None	None
Waiting Period	None	None	None	None
Eligibility Age	>19	>19	<19	<19
Network	Delta Dental PPO	Premier/Out-of-Network	Delta Dental 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.

Delta Dental PPO

Limitations and exclusions (not applicable to EHB PPO plans)

Limitations

1. Exams and cleanings[1] are limited to twice each calendar year.
2. Bitewing x-rays are limited to once per benefit period for persons age 19 and over, twice for persons age 18 and under.
3. Full mouth x-rays are limited to once every five years.
4. Topical fluoride is limited to twice each calendar year for children under age 19.
5. Space maintainers are limited to the initial appliance for children to age 14.
6. Sealants will be replaced only after two years have elapsed following any prior provision. Age limitations may vary.
7. Periodontal scaling and root planing in the same quadrant are limited to once every two years.
8. Crowns, inlays/onlays and prosthodontic appliances (bridges, dentures and implants) are limited to every five years.
9. The orthodontic maximum amount is a lifetime maximum. Benefits are not paid to repair or replace any orthodontic appliance received under a Delta Dental plan.
10. Delta Dental will base payment for optional services on the contract allowance for the covered procedure. Optional services are those elected by the enrollee in lieu of lower cost conventional services.

Exclusions

1. Treatment of injuries or illness covered by workers' compensation.
2. Cosmetic surgery or procedures for purely cosmetic reasons.
3. Maxillofacial prosthetics.
4. Provisional and/or temporary restorations.
5. Services for congenital (hereditary) or developmental (following birth) malformations.
6. Treatments or devices that increase the vertical dimension of an occlusion, restore an occlusion to normal, replace tooth structure lost by abrasion or erosion, or otherwise.
7. Services provided, supplies furnished or devices started prior to a enrollee's effective eligibility date.
8. Prescription drugs, pre-medication and relative analgesia.
9. Charges for anesthesia, other than general anesthesia or IV sedation, administered by a provider in connection with covered oral surgery or selected endodontic and periodontal surgery.
10. Experimental procedures.
11. Extraoral grafts.
12. Lab-processed crowns for children under age 12.
13. Fixed bridges and removable partials for children under age 16.
14. Indirectly fabricated resin-based inlays/onlays.
15. Services for any disturbance of the Temporomandibular (jaw) Joints (TMJ) or associated musculature, nerves and tissue except as provided under the TMJ benefit section, if applicable.
16. Missed and/or canceled appointments.

Please see the client contract and explanation of coverage for a complete list of limitations and exclusions.

[1] Pregnant enrollees may receive an additional exam and either: one additional cleaning; or periodontal scaling or root planing per quadrant in the calendar year they are pregnant.

Delta Dental EHB PPO

General exclusions applicable to covered children and/or covered adults (as noted)

The reference to a Dental Service in this section does not mean that it would otherwise be a Covered Service.

1. A Covered Person may transfer from the care of one Dentist to that of another Dentist and more than one Dentist may render the same Dental Services to the Covered Person. In that case Delta Dental shall not be liable for more than the Benefit Amount it would pay if only one Dentist rendered all these Dental Services. Nor shall Delta Dental be liable for duplication of Dental Services.
2. The following are NOT due any Benefits and Delta Dental shall NOT make any payment for or toward:
   a. Dental Services not specifically listed as Covered Services
      - unless the service is within one of the types of Covered Services and a specific code does not exist for the service, in which event the service can be considered with detailed documentation and diagnostic materials as needed by report. (applies to pediatric enrollees only)
      - including but not limited to crowns and onlays, endodontic services, periodontal services, fixed and removable prosthodontics, oral surgery, orthodontic services, maxillofacial prosthetics, implants and any services associated with implants and adjunctive general services. (applies to adult enrollees only)

   b. Dental Services covered under any other health policy or any other private or governmental health benefit system, whether insured or self-funded, unless the benefits of the other coverage are subject to coordination pursuant to the coordination of benefits provisions. (applies to pediatric enrollees only)

   c. Any Dental Service or item which is decided by Delta Dental not to be Dentally Necessary, appropriate, or meeting generally accepted standards of care, and/or lacking a reasonable prognosis for the treatment of the Covered Person's condition, disease or injury. Delta Dental reserves the right to check the Covered Person's dental records; this includes but is not limited to necessary radiographs; oral facial images; models, and financial records to decide whether a Dental Service or item meets these criteria.

   d. Dental Services for which a Claim was not submitted within twelve (12) months after the date when the Dental Service was finished. (applies to pediatric enrollees only)

      Dental Services for which a Claim was not received by Delta Dental within twelve (12) months after the date when the Dental Service was finished. (applies to adult enrollees only)

   e. Duplicative Dental Services performed on the same day.

   f. Dental Services listed in the Group Contract for which no Prior Authorization had been issued by Delta Dental within twelve (12) months prior thereto. (applies to pediatric enrollees only)

   g. Dental Services provided by or in institutions owned or operated by the federal government such as Veterans Administration facilities.

   h. Dental Services rendered outside of the United States and its territories.

   i. Dental Services for injuries or conditions which are compensable under Workmen's Compensation or Employer's Liability laws; temporary disability laws or similar and whether or not the Covered Person claims or receives benefits thereunder; Dental Services which are provided by any Federal or State or Provincial government agency, or are provided without cost to the Covered Person by any municipality, county, or political subdivision or community agency, except to the extent such payments are not enough to pay the Approved Amount therefor.

   j. Dental Services performed or items supplied for any conditions, disease, sickness, or injury occurring while the Covered Person is on active duty during military service, or for Dental Services

Delta Dental EHB PPO

General exclusions applicable to covered children and/or covered adults (as noted)

or items provided under the laws of the United States of America or of any state of the United States or any foreign country or of any political subdivision of any of the foregoing.

k. Dental Services covered under any medical policy, whether insured or self-funded. (applies to adult enrollees only)

l. A subset of a more Comprehensive Service (or a lesser Dental Service considered included in the Comprehensive Service).

m. Dental Services relating to more than the normal complement of teeth except for necessary oral surgery. (applies to pediatric enrollees only)

n. Euphoric or prescription drugs. (applies to pediatric enrollees only)

Analgesics (such as nitrous oxide) or other euphoric or prescription drugs. (applies to adult enrollees only)

o. Dental Services of a trial, experimental or investigational nature.

p. Charges for hospitalization. (applies to pediatric enrollees only)

Charges for hospitalization, including hospital visits (applies to adult enrollees only)

q. Lab tests and/or lab exams and/or medical tests, etc.

r. Specialized techniques including but not limited to swing locks, dolder bars, special staining, halder bars, connector bars, and metal bases. (applies to pediatric enrollees only)

Specialized techniques including but not limited to swing locks, dolder bars, special staining, halder bars, connector bars, metal bases, cone beam capture imaging interpretation and manipulation, ridge augmentation and/or preservation. (applies to adult enrollees only)

s. Dental Services submitted for payment as part of a Claim which has knowingly inaccurate information pertinent to the Claim (such as the Dental Service actually rendered, the date of service, the existence of other coverage, or the fee for the Dental Service).

t. Tooth preparation; acid etching; temporary restorations and crowns; bases; direct and indirect pulp caps; polishing; caries removal; microabrasion; endodontic working, final treatment, and follow up radiographs; impressions; lab fees and material; local anesthesia services in conjunction with operative or surgical procedures. (applies to pediatric enrollees only)

Tooth preparation; acid etching; temporary restorations and crowns; bases; direct and indirect pulp caps; polishing; caries removal; microabrasion; endodontic working, final treatment, and follow up radiographs; occlusal adjustments; post removal; gingivectomy In Conjunction With restorations; impressions; lab fees and material; local anesthesia services in conjunction with operative or surgical procedures, and other Dental Services which Delta Dental considers to be part of a more Comprehensive Dental Service. (applies to adult enrollees only)

u. Broken appointments.

v. Completion of Claims; copying of radiographs; providing documentation whether or not requested by Delta Dental; and requests for Prior Authorization or Pre-Treatment Estimate. (applies to pediatric enrollees only)

Completion of Claims; copying of radiographs; providing documentation whether or not requested by Delta Dental; and requests for Pre-Treatment Estimate. (applies to adult enrollees only)

w. Periodontal charting.

x. Infection control, sterile surgical setup, OSHA compliance, and other facility charges.

y. Any service that has not been performed by a person duly licensed as an oral surgeon or as a Dentist in the state in which the treatment was rendered or by their auxiliary personnel who are duly licensed to perform the services at

Delta Dental EHB PPO

General exclusions applicable to covered children and/or covered adults (as noted)

their direction. The Benefit for services performed by such auxiliary personnel shall be determined as if the Dental Service had been rendered by the oral surgeon or Dentist under whose direction the auxiliary personnel performed the services.

z. Dental Services or supplies that are cosmetic in nature. These Dental Services include but are not limited to charges for personalized or characterization of dentures.

aa. Replacement of a lost, missing or stolen prosthetic or other appliance other than a retainer. (applies to pediatric enrollees only)

bb. Home rinses and gels, toothbrushes, dental floss, personal hygiene items, other preparations and items for home use. (applies to pediatric enrollees only)

Desensitizing agents, home rinses and gels, toothbrushes, dental floss, personal hygiene items, other preparations and items for home use. (applies to adult enrollees only)

cc. Dental Services or supplies for which no charge is made that the Responsible Party/ Covered Adult is legally required to pay or for which no charge would be made if the Covered Person did not have dental coverage.

dd. Dental Services for which the Dentist does not normally charge.

ee. Dental Services performed by the Dentist for a Covered Child who is an immediate family member of the Dentist, or for a Covered Child of an immediate family member of the Dentist, or for a Covered Child in the Dentist's household. (applies to pediatric enrollees only)

Dental Services performed by the Dentist for an immediate family member of the Dentist such as mother, father, Spouse, children, brother, sister, or for a Covered Adult in the Dentist's household. (applies to adult enrollees only)

ff. Myofunctional therapy.

gg. Dental Services to correct developmental or congenital malformations, replace or repair teeth due to such conditions.

hh. Dental Services or appliances for cosmetic purposes.

ii. Dental Services to diagnose or treat jaw joint disorders, such as, but not limited to, myofascial pain syndrome and temporo mandibular joint disorders.

jj. Occlusal equilibration, occlusal analysis, and mounted case analysis. (applies to pediatric enrollees only)

Occlusal equilibration, occlusal analysis, and mounted case analysis, occlusal adjustment. (applies to adult enrollees only)

kk. Dental Services or supplies due to an accidental injury.

ll. Fees which are incurred for any injury or disease arising out of the ownership, maintenance or use of a motor vehicle, except when such charges are excluded from coverage under any automobile insurance policy or program required or provided by statute covering such Covered Person, where such exclusion is due to either an optional choice of a medical cost, deductible or an optional designation of the plan as the primary coverage.

mm. Dental Services which have not been completed during the Coverage Period except as expressly exempted in the Group Contract. (applies to pediatric enrollees only)

nn. Dental Services which have not been completed during the Coverage Period. (applies to adult enrollees only)

oo. Sales taxes on Dental Services.

The preceding represents general exclusions and limitations applicable to adult and pediatric enrollees. The group contract also includes limitations and exclusions specific to certain dental procedures. Please see the group contract for all applicable exclusions and limitations.

Delta Dental Small Business Program

Underwriting guidelines

Group size
10–50 enrolled employees

Eligible industries
See Eligible Industries page for a complete list of eligible/ineligible industries (not applicable to EHB PPO plans).

Eligible employees
Full-time, permanent employees. Contract employees (category 1099) are not eligible. Employer must submit documentation to verify employer/employee relationship. A group of two cannot be comprised of a dependent relationship (e.g., husband and wife).

Eligible dependents
Spouse (or domestic partner, if offered by group) and dependent children up to age 26. Orthodontic treatment, if applicable, covers dependent children to age 19. Dependents in military service are not eligible. Orthodontia for pediatric enrollees in EHB PPO plans is covered only when deemed medically necessary as defined in the group contract.

Eligible retirees
Retiree coverage is available in an active employee plan if there is no break in coverage and employee contribution is identical for both plans. Coverage must be available to all retirees.

Out-of-state enrollees
Eligible employees residing out-of-state may receive care from any licensed dentist, regardless of location.

Employer contribution (used to determine participation requirements)
Employee contribution must be paid through pre-tax payroll deductions.

Employer-paid
Employer contributes at least 50% of the cost of the plan.

Voluntary
Employer contributes less than 50% of the cost of the plan (employee may contribute up to 100% toward the cost of the plan).

Participation requirements (unless covered elsewhere)
All plans — If employer contributes 100% of the cost, all eligible employees must enroll. If employer contributes 100% of the cost for dependents, all eligible dependents must be enrolled.

If employer contributes:

0–49% (Voluntary) — At least 25% of all eligible employees must enroll.

50–99% (Employer-Paid) — At least 75% of eligible employees or 10, whichever is greater. At least 50% of employees with dependents must enroll their dependents.

Underwriting guidelines (continued)

Waiving coverage
Employees who contribute toward the cost of the premium for themselves and/or their dependents and employees/dependents with coverage elsewhere may have coverage waived.

Open enrollment
Employees who contribute towards the cost of coverage for themselves and/or their dependents, using pretax dollars, may enroll, terminate or change dependents status.

Termination
Dental coverage will end on the last day of the month when the primary enrollee is no longer eligible. Dependent coverage ends when a dependent is no longer eligible, or when the primary enrollee's coverage ends.

Changing benefits
Groups can only change benefits at the policy anniversary (renewal).

Waiting periods
The below waiting periods may be waived if the group can provide proof of prior comprehensive group dental coverage with no break in coverage and a copy of the most recent invoice or statement from the previous carrier.

Employer-paid plans
Groups with 10–50: No waiting period

Voluntary plans
There is a six-month waiting period for all oral surgery, endodontic and periodontic services, if covered.

There is a 12-month waiting period for all major services, if covered.

EHB plans
Waiting periods are not applicable to EHB PPO plans.

Delta Dental PPO™

Eligible/ineligible industries[1] (not applicable to EHB PPO plans)

Eligible industries

Level One	SIC code
Agriculture, Forestry, Fishing (except seasonal employees #0761-0783)	0100-0999
Mining, Oil and Gas Extraction	1000-1499
Construction Contractors	1500-1799
Manufacturing	2000-2699
Printing & Publishing	2700-2799
Manufacturing (except Jewelry Manufacturing #3911-3915)	2800-3999
Transportation	4000-4799
Communication (Radio, Telephone, TV/Radio Broadcasting)	4800-4899
Utilities	4900-4999
Wholesale Trade	5000-5199
Retail	5200-5510, 5610-5699, 5712-5736, 5912-5999
Finance (Banks, Securities, Credit Agencies)	6000-6299
Services	7100-7220, 7222-7230, 7242-7290, 7300-7318, 7320-7388, 7390-7630, 7632-7799
Employment Agencies (Management and Administrative Staff Only)	7361-7363
Hospitals	8062-8069
Medical Labs and Dental Labs	8071-8072
Community Service Organizations/Social Services/Government Funded Group	8300-8399
Museums, Art Galleries & Gardens	8400-8499
Membership/Organizations/Associations (Management and Administrative Staff only)	8600-8699

Level Two	SIC code
Jewelry Manufacturing	3911-3915
Auto Dealerships	5511-5599
Restaurants	5800-5899
Insurance Carriers/Brokers	6300-6499
Real Estate	6500-6799
Services	7000-7099, 7221, 7291-7299, 7319, 7631
Beauty & Barber Shops	7231-7241
Amusement, Recreation & Entertainment	7800-7999
Medical Groups	8000-8059 & 8082-8099
Legal	8100-8199
Private Schools (Elementary & High School)	8200-8299
Engineering, Accounting, Research, Management & Related Services	8700-8799
International Affairs	9721
Management Carve-out (regardless of industry)	9999

Ineligible industries

	SIC code
Seasonal Employees (Farm Labor & Mgt, Landscape and Horticultural services)	0761-0783
Staff Placed By Employment Agencies	7361-7363
Misc. Business Services	7389
Dentist offices	8021
Public Schools (Elementary & High School)[2]	8200-8299
Members of Membership Organizations/Associations	8600-8699
Private Households	8811
Misc. Services not elsewhere classified	8999
Public Administration (Cities, Counties, Police, etc.)[2]	9000-9720, 9722-9998
Seasonal Employees (Christmas/Part-time help)	No SIC
High Turnover[3]	Varies

[1] SIC rate level cannot change for renewing business.

[2] Public Sector Groups are an eligible industry with Delta Dental NJ/CT; they are excluded under the Small Business Program.

[3] A business has high turnover if 20% or more of the average number of its employees during the past 12 months were newly hired for reasons other than the growth of the business.

Delta Dental of New Jersey, Inc
1639 Route 10
Parsippany, NJ 07054

Carin Hep
Sales Director
(973) 944-4519
chep@deltadentalnj.com

This benefit information is only a summary and not intended or designed to replace or serve as the plan contract. Limitations and/or waiting periods may apply for some benefits; some services and procedures may be excluded from the plan. Contact your general agent or consult proposal/solicitation materials for complete information.

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**

We keep you smiling.®