DELTA DENTAL®

Delta Dental of Nebraska

2018 Individual and Family Pediatric Dental Essential Health Benefits

Certified, stand-alone pediatric dental plans for those under age 19

Pediatric dental coverage for dependents under age 19 is one of ten Essential Health Benefits (EHBs) required under the federal Patient Protection and Affordable Care Act (PPACA). Pediatric dental can be satisfied with purchase of a stand-alone dental plan and Delta Dental offers the nation's largest network of dental providers, delivering greater access to care and more cost savings.

Pediatric Dental Health Benefits	Pediatric Low		Pediatric High	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic/Preventive Routine exams and cleanings, two per calendar year, sealants, X-rays, fluoride treatments	100%	100%	100% (no deductible)	100% (no deductible)
Basic Services Fillings	50%	50%	80%	80%
Endodontics/Periodontics/Oral Surgery Root canals, treatment of gum disease, extractions	50%	50%	50%	50%
Major Services Crowns, dentures, bridges	50%	50%	50%	50%
Medically Necessary Orthodontics (24 month waiting period)	50%	50%	50%	50%
Deductible Per Person/Per Calender Year	$50		$50 (does not apply to Diagnostic/Preventive Services)	
Annual Plan Maximum Per Person/Per Calender Year	N/A	N/A	N/A	N/A
Annual Out of Pocket Maximum	$350-1 child $700-maximum for 2 or more children	N/A	$350-1 child $700-maximum for 2 or more children	N/A
2018 Premium Per Member/Per Month (Maximum 3 child premiums per family)	$22.45		$27.25	

Adult/Family Plans	Bronze	Silver	Gold	Platinum
	1 Cleaning, 1 Exam, 1 Bitewing**			
	IN/OON	IN/OON	IN/OON	IN/OON
Diagnostic/Preventive (no deductible) Routine exams and cleanings twice per calendar year *(once every calendar year for Adult Plan Bronze)*, X-rays	100%	100%	100%	100%
Basic Service Fillings	0%	50%	50%	80%
Endodontics/Periodontics/Oral Surgery Root canals, treatment of gum disease, extractions	0%	0%	50%	50%
Major Services (12-month waiting period) Crowns, dentures, bridges	0%	0%	25%	50%
Deductible Per Person/Per Calendar Year (does not apply to Diagnostic/Preventive Services)	$0	$50	$50	$50
Annual Maximum Per Person/Per Calendar Year	$500	$500	$1,000	$1,200
Annual Out-of-Pocket Maximum	n/a	n/a	n/a	n/a
2018 Premium Per Member/Per Month	$14.20	$22.50	$34.55	$42.15

For more information visit: DeltaDentalNE.org

IN - In-Network OON - Out-of-Network

Members who receive services from non-Delta Dental network dentists are covered at the same benefit levels as those who see Delta Dental PPO℠ and Delta Dental Premier® network dentists. However, because non-Delta Dental network dentists are not under contractual obligation, they may balance bill members for the amount not reimbursed under the plan. Our rates include all applicable taxes and fees. **Bitewing X-ray series once every 2 calendar years.

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