

Understanding Your Plan

Your Benefit Summary

WESTERLY SCHOOL NON-UNION

Group Number: 5858-0373

Delta Dental PPO Plus Premier™

Effective: 07/01/2025 - 06/30/2026

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. For a complete listing of frequencies and limitations go to www.deltadentalri.com/content/exclusionsandlimitations. To be covered, services must be dentally necessary and appropriate as per our review guidelines.

Icons

-  Pre-treatment Estimate Recommended
-  Prior Authorization Required
-  Deductible Applies

Provisions

Annual Maximum: \$1,200

Maximum Lifetime Cap: Unlimited

Max Carry Over: \$250

In Network Bonus: \$100

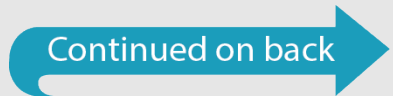
Carry Over Limit: \$1000

Individual Deductible: \$0

Family Deductible: \$0

Dependent Coverage - Dependent children are covered under these benefits up until the end of the month that they turn 26.

Procedure	Covered At	Frequency / Limitations
DIAGNOSTIC		
Oral exam	100%	Twice per calendar year
Bitewing x-rays	100%	One set per calendar year
Complete x-ray series or panoramic film	100%	Once every 36 months.
Single x-rays	100%	As required
PREVENTIVE		
Cleaning	100%	Twice per calendar year
Fluoride treatment	100%	For children under age 19 once per calendar year
Sealants	100%	For children under age 16, once every 24 months on unrestored permanent bicuspid and molars
Space maintainers	100%	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	100%	
 Crowns over natural teeth, build ups, posts and cores	100%	Replacement limited to once every 60 months
Recementing crowns or bridges	100%	Once every 60 months
ENDODONTICS		
Root canal therapy on permanent teeth	100%	One procedure per tooth per lifetime.

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Icons

- P** Pre-treatment Estimate Recommended
- A** Prior Authorization Required
- D** 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.

Procedure	Covered At	Frequency / Limitations
PERIODONTICS		
P Root planing and scaling	50%	Once per quadrant every 24 months
P Osseous (bone) surgery	50%	Once per quadrant every 36 months (bone grafts are not covered)
P Gingivectomies	50%	Once per site every 36 months
P Soft tissue grafts	50%	Once per site every 60 months
P Crown lengthening	50%	Once per site every 60 months
Periodontal maintenance following active therapy	50%	Two per year
PROSTHODONTICS		
P Bridges and crowns over implants	50%	Replacement limited to once every 60 months
P Partial and complete dentures	50%	Replacement limited to once every 60 months
Repairs to existing partial or complete dentures	100%	Once per calendar year
Rebasing or relining of partial or complete dentures	100%	Once every 60 months
EXTRACTIONS AND ORAL SURGERY		
Extractions and other routine oral surgery when not covered by a patient's medical plan	100%	
OTHER SERVICES		
Palliative treatment (minor procedures necessary to relieve acute pain)	100%	Twice per calendar year
General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures	100%	

Note: This plan does not include a missing tooth clause. In addition, if covered, 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.