

# Episcopal Diocese of Maine

Group #: 6263

Effective January 1, 2008

**Your Northeast Delta Dental program includes all of the following coverage categories. Please refer to your benefit booklet for complete benefit information. This chart is provided for summary purposes only. In the event of a conflict or discrepancy between the chart and either the group contract or the benefit booklet, the contract or benefit booklet will prevail.**

Type	Diagnostic & Preventive (Referred to as Coverage A)	Basic Restorative (Referred to as Coverage B)	Major Restorative (Referred to as Coverage C)	Orthodontics (Referred to as Coverage D)
<b>Covered Services</b>	<p><b>DIAGNOSTIC:</b> Evaluations once in a 6-month period</p> <p>X-Rays (complete series or panoramic film) once in a 3-year period, bitewing X-Rays once each 12-month period, X-Rays of individual teeth as necessary</p> <p><b>PREVENTIVE:</b> Cleanings <b>four</b> times in a 12-month period</p> <p>Fluoride twice in a 12-month period to age 19</p> <p>Space maintainers to age 16</p> <p>Sealants once per permanent molar in a 3-year period to age 19</p>	<p><b>RESTORATIVE:</b> Amalgam fillings Composite (white) fillings (anterior teeth only)</p> <p><b>ORAL SURGERY:</b> Surgical and routine extractions</p> <p><b>ENDODONTICS:</b> Root canal therapy</p> <p><b>PERIODONTICS:</b> Periodontal Cleaning (Maintenance procedures) <b>Note:</b> <i>Four cleanings are covered in a 12-month period. These may be any combination of routine (Coverage A) or Periodontal (Coverage B).</i></p> <p>Treatment of gum disease</p> <p><b>DENTURE REPAIR:</b> Repair of removable denture to its original condition</p> <p><b>EMERGENCY PALLIATIVE TREATMENT</b></p>	<p><b>PROSTHODONTICS:</b> Removable and fixed partial dentures (bridge); complete dentures</p> <p>Rebase and reline (dentures)</p> <p>Crowns</p> <p>Onlays</p> <p>Implants</p>	<p><b>ORTHODONTICS:</b> Correction of malposed (crooked) teeth for adults and dependent children to age 19</p>
<b>Waiting Period</b>	None	6 Months	12 Months	24 Months
<b>Deductible</b>	No Deductible	\$100/\$300 Lifetime Deductible Per Person/Family		No Deductible
<b>Coinsurance</b>	Delta Dental Pays 100%	After Deductible and Waiting Period, Delta Dental Pays 80%	After Deductible and Waiting Period, Delta Dental Pays 50%	After Waiting Period, Delta Dental Pays 50%
<b>Maximum</b>	Coverage A, B and C <b>Combined</b> Calendar Year Maximum (January 1 – December 31): \$1,500 Per Person			<b>Lifetime</b> Maximum: \$1,500 Per Person

**Benefit percentages shown are based upon the actual charge submitted to a maximum of the participating dentist's approved fees, or Delta Dental's allowance for nonparticipating dentists.**