



Delta Dental PPOSM Plans with Individual Kids Preferred Plan Companion/Rider for Small Groups

Affordable Care Act (ACA) Compliant Dental Plans

Our pediatric dental plan, Individual Kids Preferred plan, meets the guidelines of the Affordable Care Act's (ACA) Pediatric Dental Essential Health Benefit (EHB).

Delta Dental of Illinois offers small groups (2-50 employees) a plan companion/rider to our small group PPO plan offerings that meets the pediatric dental EHB required by the ACA. **Groups do not have to purchase pediatric dental coverage from a medical carrier, and the pediatric dental EHB does not have to be embedded in a medical plan.** With Delta Dental of Illinois' exchange-certified dental plan – Individual Kids Preferred – groups that add it can provide “reasonable assurance”/attest to their medical carriers of Pediatric Dental EHB coverage by a stand-alone dental carrier. Additionally, benefits do not have to be purchased from a public insurance exchange.

Delta Dental PPO plans with the Individual Kids Preferred plan use an Exclusive Provider Feature. With an Exclusive Provider Feature, benefits are paid only when a member sees a Delta Dental PPO dentist. There are no benefits when a member sees a dentist outside of the Delta Dental PPO network. However, members under age 19 can use the benefits of the PPO plan and the Individual Kids Preferred plan, but can only receive benefits from the Individual Kids Preferred plan with Delta Dental PPO dentists.

Delta Dental PPOSM Platinum Plan with the Individual Kids Preferred Plan

| Delta Dental PPO SM Platinum Plan | | Individual Kids Preferred Plan | | | | | | | | | | | | | | | | |
|---|--|--|--|--------------------|---------------|---------------|--|------|-------|--|------|-------|--|---|--|--|--|--|
| <p>All plans are based on the Delta Dental PPO network. Delta Dental PPO dentists cannot bill over the PPO allowed amount. Delta Dental Premier and non-network dentists can bill for charges above the allowed Delta Dental PPO amount. However, Delta Dental Premier dentists cannot bill for charges above the allowed Delta Dental Premier amount.</p> | | <p style="text-align: center;"><i>(Children under age 19 only)</i></p> <p>The Individual Kids Preferred plan uses an Exclusive Provider Feature where benefits are paid only when a member uses a Delta Dental PPO dentist. Delta Dental PPO dentists cannot bill members for charges over the PPO allowed amount. There are no benefits when a member uses a non-Delta Dental PPO network dentist. The plan is offered as a companion/rider to Delta Dental PPO Platinum, Gold and Silver plans. Members under age 19 can use the benefits of both the Platinum and Individual Kids Preferred plans but can only receive benefits from the Individual Kids Preferred plan with Delta Dental PPO dentists.</p> | | | | | | | | | | | | | | | | |
| | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">Delta Dental PPOSM</td> <td style="width: 33%; text-align: center;">Delta Dental Premier[®]</td> <td style="width: 33%; text-align: center;">Non-Network</td> </tr> <tr> <td style="text-align: center;">Single</td> <td style="text-align: center;">Family</td> <td></td> </tr> <tr> <td style="text-align: center;">\$50</td> <td style="text-align: center;">\$150</td> <td></td> </tr> <tr> <td style="text-align: center;">\$75</td> <td style="text-align: center;">\$225</td> <td></td> </tr> <tr> <td colspan="3" style="text-align: center; font-size: small;">Applies to Coverages B and C only. Optional for Coverage A.</td> </tr> </table> | Delta Dental PPOSM | Delta Dental Premier[®] | Non-Network | Single | Family | | \$50 | \$150 | | \$75 | \$225 | | Applies to Coverages B and C only. Optional for Coverage A. | | | | |
| Delta Dental PPOSM | Delta Dental Premier[®] | Non-Network | | | | | | | | | | | | | | | | |
| Single | Family | | | | | | | | | | | | | | | | | |
| \$50 | \$150 | | | | | | | | | | | | | | | | | |
| \$75 | \$225 | | | | | | | | | | | | | | | | | |
| Applies to Coverages B and C only. Optional for Coverage A. | | | | | | | | | | | | | | | | | | |
| Deductible Options | | Deductible <i>(benefit year; per person, applies to basic and major services only)</i> | \$50 | | | | | | | | | | | | | | | |
| Out-of-Pocket Limit | N/A | Out-of-Pocket Limit | \$350 per individual child | | | | | | | | | | | | | | | |
| Annual Maximum Options | \$1,000, \$1,500 or \$1,800 | Family Out-of-Pocket Limit <i>(for children under age 19)</i> | \$700 | | | | | | | | | | | | | | | |
| Coverage A Diagnostic: <ul style="list-style-type: none"> • Exams <i>(limited to 2 per person in a benefit year)</i> • Bitewing X-rays <i>(limited to 2 per person in a benefit year)</i> • Full-Mouth X-rays <i>(every three years)</i> Preventive: <ul style="list-style-type: none"> • Cleanings <i>(limited to 2 per person in a benefit year)</i> • Fluoride Treatments <i>(limited to 1 per person in a benefit year, under age 19)</i> • Space Maintainers <i>(under age 14)</i> | 100%* | Preventive Services <ul style="list-style-type: none"> • Exams <i>(limited to 2 per person in a benefit year)</i> • Cleanings <i>(limited to 2 per person in a benefit year)</i> • Bitewing X-rays <i>(limited to 2 per person in a benefit year)</i> • X-rays <i>(full mouth/panoramic – limited to 1 per person in 36 months)</i> • Fluoride Treatments <i>(limited to 1 per person in a benefit year, under age 19)</i> • Space Maintainers <i>(under age 19)</i> • Sealants <i>(under age 19)</i> | 100% in-network/ 0% out-of-network | | | | | | | | | | | | | | | |
| Coverage B Basic Restorative: <ul style="list-style-type: none"> • Sealants <i>(under age 16)</i> • Fillings/Amalgams/Composites <i>(including posterior composites)</i> Non-Surgical Periodontics**: <ul style="list-style-type: none"> • Non-Surgical Treatment of Gum Disease Endodontics**: <ul style="list-style-type: none"> • Root Canals and Pulpal Therapy • Oral Surgery, Simple Extractions Oral Surgery, Surgical Extractions** <i>(including preoperative and postoperative care)</i> <p style="font-size: x-small;">** These benefits can be moved as a coverage grouping to Coverage C.</p> | 80%* | Basic Services <ul style="list-style-type: none"> • Fillings/Amalgams • Simple Extractions • Gum Disease Treatment • Root Canals • Surgical Extractions | 80% in-network/ 0% out-of-network | | | | | | | | | | | | | | | |
| Coverage C Major Restorative: <ul style="list-style-type: none"> • Cast Restorations: Crowns, Onlays and Other Ceramic Restorations to Permanent Teeth • Implant Therapy Prosthetics: <ul style="list-style-type: none"> • Bridges, Partial Dentures and Complete Dentures Surgical Periodontics <ul style="list-style-type: none"> • Surgical Treatment of Gum Disease | 50%* | Major Services <ul style="list-style-type: none"> • Denture Relines and Rebases, Adjustments • Repairs to Crowns, Dentures and Bridges • Crowns • Complete and Partial Dentures • Fixed Bridgework | 50% in-network/ 0% out-of-network | | | | | | | | | | | | | | | |
| Coverage D Orthodontics <i>(for children under age 19)</i> Optional and available to all groups | 50%* | Orthodontia <i>(medically necessary orthodontia only)</i> The ACA requires coverage for medically necessary orthodontia only. Predeterminations will be necessary to determine if there is any coverage for orthodontia under the Individual Kids Preferred plan. | 50% in-network/ 0% out-of-network | | | | | | | | | | | | | | | |
| Orthodontia Maximum Options Optional and available to all groups | \$1,000 or \$1,500 | Orthodontia Maximum Options Optional and available to all groups | N/A | | | | | | | | | | | | | | | |
| Enhanced Benefits Program Offers additional coverage for individuals who have specific health conditions (including pregnancy, diabetes, high-risk cardiac conditions and suppressed immune systems) that can be positively affected by additional oral health care. | Included | Enhanced Benefits Program Offers additional coverage for individuals who have specific health conditions (including pregnancy, diabetes, high-risk cardiac conditions and suppressed immune systems) that can be positively affected by additional oral health care. | Included | | | | | | | | | | | | | | | |

* In-network payment is based on discounted fees; Delta Dental Premier and out-of-network payment is based on Delta Dental of Illinois' Maximum Plan Allowance (MPA).

Delta Dental PPOSM Gold Plan with the Individual Kids Preferred Plan

| Delta Dental PPO SM Gold Plan | | | | Individual Kids Preferred Plan | |
|---|---|-----------------------------------|-------------|---|--|
| All plans are based on the Delta Dental PPO network. Delta Dental PPO dentists cannot bill over the PPO allowed amount. Delta Dental Premier and non-network dentists can bill for charges above the allowed Delta Dental PPO amount. However, Delta Dental Premier dentists cannot bill for charges above the allowed Delta Dental Premier amount. | | | | <i>(Children under age 19 only)</i> The Individual Kids Preferred plan uses an Exclusive Provider Feature where benefits are paid only when a member uses a Delta Dental PPO dentist. Delta Dental PPO dentists cannot bill members for charges over the PPO allowed amount. There are no benefits when a member uses a non-Delta Dental PPO network dentist. The plan is offered as a companion/rider to Delta Dental PPO Platinum, Gold and Silver plans. Members under age 19 can use the benefits of both the Gold and Individual Kids Preferred plans but can only receive benefits from the Individual Kids Preferred plan with Delta Dental PPO dentists. | |
| | Delta Dental PPO SM | Delta Dental Premier [®] | Non-Network | | |
| Deductible Options | Single Family \$50 \$150 \$75 \$225 Applies to Coverages B and C only. Optional for Coverage A. | | | Deductible <i>(benefit year; per person, applies to basic and major services only)</i> | \$50 |
| Out-of-Pocket Limit | N/A | | | Out-of-Pocket Limit | \$350 per individual child |
| Annual Maximum Options | \$1,000, \$1,500 or \$1,800 | | | Family Out-of-Pocket Limit <i>(for children under age 19)</i> | \$700 |
| Coverage A Diagnostic: <ul style="list-style-type: none"> • Exams <i>(limited to 2 per person in a benefit year)</i> • Bitewing X-rays <i>(limited to 2 per person in a benefit year)</i> • Full-Mouth X-rays <i>(every three years)</i> Preventive: <ul style="list-style-type: none"> • Cleanings <i>(limited to 2 per person in a benefit year)</i> • Fluoride Treatments <i>(limited to 1 per person in a benefit year, under age 19)</i> • Space Maintainers <i>(under age 14)</i> | 100%* | | | Preventive Services <ul style="list-style-type: none"> • Exams <i>(limited to 2 per person in a benefit year)</i> • Cleanings <i>(limited to 2 per person in a benefit year)</i> • Bitewing X-rays <i>(limited to 2 per person in a benefit year)</i> • X-rays <i>(full mouth/panoramic – limited to 1 per person in 36 months)</i> • Fluoride Treatments <i>(limited to 1 per person in a benefit year, under age 19)</i> • Space Maintainers <i>(under age 19)</i> • Sealants <i>(under age 19)</i> | 100% in-network/ 0% out-of-network |
| Coverage B Basic Restorative: <ul style="list-style-type: none"> • Sealants <i>(under age 16)</i> • Fillings/Amalgams/Composites <i>(including posterior composites)</i> Non-Surgical Periodontics**: <ul style="list-style-type: none"> • Non-Surgical Treatment of Gum Disease Endodontics**: <ul style="list-style-type: none"> • Root Canals and Pulpal Therapy • Oral Surgery, Simple Extractions Oral Surgery, Surgical Extractions** <i>(including preoperative and postoperative care)</i> ** These benefits can be moved as a coverage grouping to Coverage C. | 80%* | 60%* | 60%* | Basic Services <ul style="list-style-type: none"> • Fillings/Amalgams • Simple Extractions • Gum Disease Treatment • Root Canals • Surgical Extractions | 80% in-network/ 0% out-of-network |
| Coverage C Major Restorative: <ul style="list-style-type: none"> • Cast Restorations: Crowns, Onlays and Other Ceramic Restorations to Permanent Teeth Implant Therapy Prostheticodontics: <ul style="list-style-type: none"> • Bridges, Partial Dentures and Complete Dentures Surgical Periodontics <ul style="list-style-type: none"> • Surgical Treatment of Gum Disease | 50%* | | | Major Services <ul style="list-style-type: none"> • Denture Relines and Rebases, Adjustments • Repairs to Crowns, Dentures and Bridges • Crowns • Complete and Partial Dentures • Fixed Bridgework | 50% in-network/ 0% out-of-network |
| Coverage D Orthodontics <i>(for children under age 19)</i> Optional and available to all groups | 50%* | | | Orthodontia <i>(medically necessary orthodontia only)</i> The ACA requires coverage for medically necessary orthodontia only. Predeterminations will be necessary to determine if there is any coverage for orthodontia under the Individual Kids Preferred plan. | 50% in-network/ 0% out-of-network |
| Orthodontia Maximum Options Optional and available to all groups | \$1,000 or \$1,500 | | | Orthodontia Maximum Options Optional and available to all groups | N/A |
| Enhanced Benefits Program Offers additional coverage for individuals who have specific health conditions (including pregnancy, diabetes, high-risk cardiac conditions and suppressed immune systems) that can be positively affected by additional oral health care. | Included | | | Enhanced Benefits Program Offers additional coverage for individuals who have specific health conditions (including pregnancy, diabetes, high-risk cardiac conditions and suppressed immune systems) that can be positively affected by additional oral health care. | Included |

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Delta Dental PPOSM Silver Plan with the Individual Kids Preferred Plan

| Delta Dental PPO SM Silver Plan | | | | | Individual Kids Preferred Plan | | | | | | |
|--|--|---|--------------------|---|--|------|-------|------|-------|---|------|
| All plans are based on the Delta Dental PPO network. Delta Dental PPO dentists cannot bill over the PPO allowed amount. Delta Dental Premier and non-network dentists can bill for charges above the allowed Delta Dental PPO amount. However, Delta Dental Premier dentists cannot bill for charges above the allowed Delta Dental Premier amount. | | | | | <i>(Children under age 19 only)</i> The Individual Kids Preferred plan uses an Exclusive Provider Feature where benefits are paid only when a member uses a Delta Dental PPO dentist. Delta Dental PPO dentists cannot bill members for charges over the PPO allowed amount. There are no benefits when a member uses a non-Delta Dental PPO network dentist. The plan is offered as a companion/ rider to Delta Dental PPO Platinum, Gold and Silver plans. Members under age 19 can use the benefits of both the Silver and Individual Kids Preferred plans but can only receive benefits from the Individual Kids Preferred plan with Delta Dental PPO dentists. | | | | | | |
| | Delta Dental PPOSM | Delta Dental Premier[®] | Non-Network | | | | | | | | |
| Deductible Options | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center; padding: 5px;">Single</td> <td style="text-align: center; padding: 5px;">Family</td> </tr> <tr> <td style="text-align: center; padding: 5px;">\$50</td> <td style="text-align: center; padding: 5px;">\$150</td> </tr> <tr> <td style="text-align: center; padding: 5px;">\$75</td> <td style="text-align: center; padding: 5px;">\$225</td> </tr> </table> <p style="font-size: small; text-align: center;">Applies to Coverages B and C only. Optional for Coverage A.</p> | | | Single | Family | \$50 | \$150 | \$75 | \$225 | Deductible <i>(benefit year; per person, applies to basic and major services only)</i> | \$50 |
| Single | Family | | | | | | | | | | |
| \$50 | \$150 | | | | | | | | | | |
| \$75 | \$225 | | | | | | | | | | |
| Out-of-Pocket Limit | N/A | | | Out-of-Pocket Limit | \$350 per individual child | | | | | | |
| Annual Maximum Options | \$1,000, \$1,500 or \$1,800 | | | Family Out-of-Pocket Limit <i>(for children under age 19)</i> | \$700 | | | | | | |
| Coverage A Diagnostic: <ul style="list-style-type: none"> • Exams <i>(limited to 2 per person in a benefit year)</i> • Bitewing X-rays <i>(limited to 2 per person in a benefit year)</i> • Full-Mouth X-rays <i>(every three years)</i> Preventive: <ul style="list-style-type: none"> • Cleanings <i>(limited to 2 per person in a benefit year)</i> • Fluoride Treatments <i>(limited to 1 per person in a benefit year, under age 19)</i> • Space Maintainers <i>(under age 14)</i> | 100%* | 80%* | 80%* | Preventive Services <ul style="list-style-type: none"> • Exams <i>(limited to 2 per person in a benefit year)</i> • Cleanings <i>(limited to 2 per person in a benefit year)</i> • Bitewing X-rays <i>(limited to 2 per person in a benefit year)</i> • X-rays <i>(full mouth/panoramic – limited to 1 per person in 36 months)</i> • Fluoride Treatments <i>(limited to 1 per person in a benefit year, under age 19)</i> • Space Maintainers <i>(under age 19)</i> • Sealants <i>(under age 19)</i> | 100% in-network/ 0% out-of-network | | | | | | |
| Coverage B Basic Restorative: <ul style="list-style-type: none"> • Sealants <i>(under age 16)</i> • Fillings/Amalgams/Composites <i>(including posterior composites)</i> Non-Surgical Periodontics**: <ul style="list-style-type: none"> • Non-Surgical Treatment of Gum Disease Endodontics**: <ul style="list-style-type: none"> • Root Canals and Pulpal Therapy • Oral Surgery, Simple Extractions Oral Surgery, Surgical Extractions** <i>(including preoperative and postoperative care)</i> <small>** These benefits can be moved as a coverage grouping to Coverage C.</small> | 80%* | 60%* | 60%* | Basic Services <ul style="list-style-type: none"> • Fillings/Amalgams • Simple Extractions • Gum Disease Treatment • Root Canals • Surgical Extractions | 80% in-network/ 0% out-of-network | | | | | | |
| Coverage C Major Restorative: <ul style="list-style-type: none"> • Cast Restorations: Crowns, Onlays and Other Ceramic Restorations to Permanent Teeth • Implant Therapy Prosthetics: <ul style="list-style-type: none"> • Bridges, Partial Dentures and Complete Dentures Surgical Periodontics <ul style="list-style-type: none"> • Surgical Treatment of Gum Disease | | 50%* | | Major Services <ul style="list-style-type: none"> • Denture Relines and Rebases, Adjustments • Repairs to Crowns, Dentures and Bridges • Crowns • Complete and Partial Dentures • Fixed Bridgework | 50% in-network/ 0% out-of-network | | | | | | |
| Coverage D Orthodontics <i>(for children under age 19)</i> Optional and available to all groups | | 50%* | | Orthodontia <i>(medically necessary orthodontia only)</i> The ACA requires coverage for medically necessary orthodontia only. Predeterminations will be necessary to determine if there is any coverage for orthodontia under the Individual Kids Preferred plan. | 50% in-network/ 0% out-of-network | | | | | | |
| Orthodontia Maximum Options Optional and available to all groups | \$1,000 or \$1,500 | | | Orthodontia Maximum Options Optional and available to all groups | N/A | | | | | | |
| Enhanced Benefits Program Offers additional coverage for individuals who have specific health conditions (including pregnancy, diabetes, high-risk cardiac conditions and suppressed immune systems) that can be positively affected by additional oral health care. | Included | | | Enhanced Benefits Program Offers additional coverage for individuals who have specific health conditions (including pregnancy, diabetes, high-risk cardiac conditions and suppressed immune systems) that can be positively affected by additional oral health care. | Included | | | | | | |

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