

This chart represents the approximate level of coverage for services performed by dentists who participate in the DeltaPremier network. It also indicates any limitations that may exist for each service. The limitations reflect the availability of coverage only. It is up to you and your dentist to determine the need and frequency of dental procedures. Please see the reverse side of this page for information about how to use your plan.

**BTU Retired Teachers Chapter  
Group Number: 6039**

<b>Type I</b> Preventive	<b>Type II</b> Basic Restorative	<b>Type III</b> Major Restorative
<b>Deductible:</b> None	<b>Calendar Year Deductible:</b> Type II & III Combined \$50 Individual	
<b>Covered at 100%</b>	<b>Covered at 50%</b>	<b>Covered at 50%</b>
<p><b>Diagnostic:</b> Initial Oral Exam – <i>Once per dentist</i> Periodic Oral Exams – <i>Twice per calendar year</i> Full Mouth X-rays – <i>once every 60 months</i> Bitewing X-rays – <i>Once every 60 months</i> Single Tooth X – <i>As needed</i></p> <p><b>Preventive:</b> Teeth Cleaning – <i>twice per calendar year</i></p>	<p><b>Restorative:</b> Silver Fillings – <i>Once every 24 months per surface per tooth</i>  White Fillings – <i>Once every 24 months per surface per tooth on front teeth: single surface only on back teeth</i> Temporary Fillings – <i>Once per tooth</i> Stainless Steel Crown (baby teeth only) – <i>Once every 24 months per tooth.</i></p> <p><b>Oral Surgery:</b> <i>Oral surgical benefits not provided when rendered in a surgical day care or hospital setting</i> Simple Extractions Surgical Extractions</p> <p><b>Periodontics:</b> Periodontal Surgery – <i>Periodontal benefits not provided when rendered in a surgical day care or hospital setting</i> Scaling and Root Planning – <i>Once in 24 months, per quadrant</i> Periodontal Cleaning – <i>Four periodontal cleanings in a calendar year following active periodontal treatment. Not to exceed 2 in a calendar year when combined with preventive cleanings.</i></p> <p><b>Endodontics:</b> Root Canal Treatment – <i>Once per tooth</i> Vital Pulpotomy – <i>Limited to deciduous teeth on covered members.</i></p> <p><b>Prosthetic Maintenance:</b> Bridge or Denture Repair – <i>Once within 12 months, same repair</i> Rebase or Reline of Dentures – <i>Once within 26 months</i> Recement of Crowns and Onlays – <i>Once within 12 months per tooth</i></p> <p><b>Emergency Dental Care:</b> Minor Treatment for Pain Relief – <i>Three occurrences in 12 months</i> General Anesthesia – <i>Allowed with covered surgical services only.</i></p>	<p><b>Prosthodontics:</b> Dentures – <i>Once within 60 months</i> Fixed Bridges and Crowns (when part of a bridge) – <i>Once within 60 months.</i></p> <p><b>Major Restorative:</b> Crowns (when teeth cannot be restored with regular fillings) – <i>Once within 60 months per tooth.</i></p>

**CALENDAR YEAR MAXIMUM: \$1, 000.00 PER PERSON**