Small Group Dental Solutions
2-9 Enrolled Employees

Indiana
2025 Effective Dates
One-year contract

Delta Dental PPO™ (Point-of-Service)						
Non-EHB Benefits	**Base Plan A**			**Base Plan B**		
Network Access	**Delta Dental PPO™**	**Delta Dental Premier®/ Nonparticipating**	**Covered Services**	**Delta Dental PPO™**	**Delta Dental Premier®/ Nonparticipating**	**Covered Services**
Diagnostic & Preventive Services	100%	100%	Exams, cleanings, fluoride, space maintainers, palliative treatment, brush biopsy, and radiographs	100%	100%	Exams, cleanings, fluoride, space maintainers, palliative treatment, and brush biopsy
Basic Services	80%	80%	Minor restorative services, periodontal maintenance, simple extractions, and relines and repairs	80%	60%	Radiographs, minor restorative services, periodontal maintenance, simple extractions and relines and repairs
Major Services	50%	50%	Endodontics, periodontics, other oral surgery, major restorative services, other basic services, and prosthodontics	50%	40%	Endodontics, periodontics, other oral surgery, major restorative services, other basic services, and prosthodontics
Maximum Payment – per person per calendar year	$1,000			$1,000		
Deductible – per person/per family per calendar year	$50/$150 Applies to basic and major services			$75/$225 Applies to basic and major services		
EHB Plan Required (see page two for details)	Yes		No	Yes		No

Please choose one option from either Plan A or Plan B below:

	Plan A Buy-Up Options and Rates[1,2]		Plan B Buy-Up Options and Rates[1,2]	
	Plan A - as outlined above (#8880)	**Plan A + Endodontic and Periodontic Services covered as Basic Services (#8881)**	**Plan B - as outlined above (#8884)**	**Plan B + Endodontic and Periodontic Services covered as Basic Services (#8885)**
Subscriber	$30.98	$32.45	$26.04	$27.28
Subscriber + spouse	$61.96	$64.90	$52.09	$54.56
Subscriber + child(ren)	$77.45	$79.18	$65.10	$66.56
Family	$109.66	$112.92	$92.18	$94.93

	Plan A + $1,500 Annual Maximum (#8882)	**Plan A + Endodontics and Periodontics covered as Basic Services & $1,500 Annual Maximum (#8883)**	**Plan B + $1,500 Annual Maximum (#8886)**	**Plan B + Endodontics and Periodontics covered as Basic Services & $1,500 Annual Maximum (#8887)**
Subscriber	$33.81	$35.41	$28.42	$29.77
Subscriber + spouse	$67.62	$70.82	$56.84	$59.54
Subscriber + child(ren)	$83.51	$85.37	$70.20	$71.76
Family	$118.66	$122.18	$99.75	$102.71

[1] Rates do not include any applicable claims taxes.
[2] Rates are for both Non-EHB plans and plans that require EHB benefits for members age 18 and under.

PA 07/2024

DELTA DENTAL®

Small Group Dental Solutions
2-9 Enrolled Employees

Indiana
2025 Effective Dates
One-year contract

Participation Requirements:

Immediate family members must be enrolled on one application and count as one eligible member. At least 75 percent of the employees must be physically located in the state where the contract is held.

Participation Requirements		
Number Eligible	2-7	8+
Minimum Insured	2	25%

Certified EHB Benefits (for members age 18 and under)

EHB Note: If EHB is selected, any Non-EHB covered services that are not covered in the pediatric plan will be covered for people age 18 and under, subject to the Non-EHB limitations and maximum payment provisions. For all EHB covered services provided by a Delta Dental PPO™ (Point-of-Service) or Delta Dental Premier® dentist, the maximum out-of-pocket payments are $425 per calendar year for one person age 18 and under or $850 per calendar year per family with two or more people age 18 and under. An individual will be considered age 18 and under until the end of the Benefit Year in which the individual attains the age of 19.

Certified EHB High Plan Delta Dental PPO™ (Point-of-Service)			
Network Access	**Delta Dental PPO™**	**Delta Dental Premier®/ Nonparticipating**	**Covered Services**
Diagnostic & Preventive Services	100%	100%	Exams, cleanings, fluoride, space maintainers, palliative treatment, radiographs, and sealants
Basic Services	80%	60%	Minor restorative services, endodontics, periodontics, oral surgery, other basic services, and relines and repairs to prosthetic appliances
Major Services	50%	50%	Major restorative services, bridges, dentures, implants, and crowns over implants
Orthodontic Services	50%	50%	Medically necessary orthodontics
Maximum (per person, per calendar year)	None See above for maximum out-of-pocket details		
Deductible (per person/per family, per calendar year)	$50/$150 Applies to basic and major services		

To enroll, complete the Group Information Form and return to your Account Manager at Delta Dental along with enrollment information and proof of prior dental coverage (if applicable) and first month's premium.
Group Information Form:
To download, visit the Producers section of our website at
www.deltadentalin.com
Questions? Ph: 800-382-5404 | Email: smallmarket@deltadentalin.com

PA 07/2024