



Effective Date:

		Basic Plan	Core Plan	Premium Plan
	Member Only	\$23.81	\$31.90	\$56.45
	Member + 1 Child	\$51.60	\$64.02	\$122.23
	Member + Spouse	\$48.02	\$61.41	\$115.97
	Member + Child(ren)	\$51.60	\$64.02	\$122.23
	Member + 1 Family	\$82.20	\$105.10	\$203.83

Mail: ATTN: Insurance Department
1621 Midtown Place
Raleigh, NC 27609

Social Security Number: - -						SEANC#	
Your Name:		First Name				Middle Initial	Last Name
Birth Date:		/ /	Gender: ▪ M ▪ F		Marital Status: ▪ Single ▪ Married ▪ Divorced ▪ Widowed ▪ Domestic Partnership		
Address:							
Home Phone: () -						Work Phone: () -	
Cell Phone: () -						Personal email address:	

		First Name	Last Name	Birth Date	Gender
	Spouse			/ /	M F
	Child			/ /	M F
	Child			/ /	M F
	Child			/ /	M F
	Child			/ /	M F

Date _____

State Employees Association of North Carolina

	Premium Plan	Core Plan	Basic Plan
Annual Maximum Benefit*	\$5,000	In - \$1,500 Out - \$1,250	\$1,250
Orthodontia Lifetime Policy Maximum	\$2,000	Not Covered	Not Covered
Deductible (Individual)	\$50	\$25	\$25
Deductible (Family)	\$150	\$75	\$75
Preventive and Diagnostic Services			
Preventive & Diagnostic Co-Insurance	In - 100% Out - 80%	In - 100% Out - 80%	In - 100% Out - 80%
Oral evaluation Exams (Routine Exam)	2 times per calendar year	2 times per calendar year	2 times per calendar year
Dental Prophylaxis (Teeth Cleaning) *	2 times per calendar year *	2 times per calendar year *	2 times per calendar year *
Fluoride Treatments	2 times per calendar year to age 16	2 times per calendar year to age 16	2 times per calendar year to age 16
Intraoral Radiographs (Full Mouth X-rays)	1 time per 3 year period (complete series and Panorex)	1 time per 3 year period (complete series and Panorex)	1 time per 3 year period (complete series and Panorex)
Bitewing and Extraoral X-rays Adults and child(ren)	Bitewing: 2 per calendar year Extraoral: 2 films per calendar year	Bitewing: 2 per calendar year Extraoral: 2 films per calendar year	Bitewing: 2 per calendar year Extraoral: 2 films per calendar year
Space maintainers	1 per 5 year period for dependent children to age 16.	1 per 5 year period for dependent children to age 16.	1 per 5 year period for dependent children to age 16.
Brush Biopsy	Covered	Covered	Covered
Basic Services			
Basic Co-Insurance	In - 80% Out - 60%	In - 80% Out - 60%	In - 70% Out - 50%
Sealants	Once per first or second permanent molar every 36 months for dependent children to age 16.	Once per first or second permanent molar every 36 months for dependent children to age 16.	Once per first or second permanent molar every 36 months for dependent children to age 16.
Simple Extractions	Covered	Covered	Covered
Restorations (Routine Fillings)	Covered	Covered	Covered
Periodontal maintenance	2 times per calendar year with a documented history of periodontal disease	2 times per calendar year with a documented history of periodontal disease	2 times per calendar year with a documented history of periodontal disease
Palliative Treatment	Covered	Covered	Covered
Major Services			
Major Co-Insurance	In - 50% Out - 25%	In - 50% Out - 25%	0% Not Covered
Endodontics	Covered	Covered	Not Covered
Denture Repairs	12 months after initial insertion, 1 time per 6 months	12 months after initial insertion, 1 time per 6 months	Not Covered
Adjustment to Dentures	12 months after initial insertion, 1 time per 6 months	12 months after initial insertion, 1 time per 6 months	Not Covered
Oral Surgery	Covered	Covered	Not Covered
Periodontal Scaling and Root Planing	One time per quadrant per consecutive 24 months	One time per quadrant per consecutive 24 months	Not Covered
Root Canal Therapy	1 time per tooth per lifetime	1 time per tooth per lifetime	Not Covered
Periodontal Surgery	Once per quadrant or site every consecutive 36 months	Once per quadrant or site every consecutive 36 months	Not Covered
Oral Surgery - Other/Surgical	Covered	Covered	Not Covered
Anesthesia	Covered as a basic service	Covered as a basic service	Covered as a basic service
Bridges/Dentures	Full Denture/Partial Denture: 1 per five year period Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months.	Full Denture/Partial Denture: 1 per five year period. Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months.	Not Covered
Crowns/Inlays/Onlays	1 time per tooth per five year period Crown replacement: 1 time per five year period from initial or supplemental placement.	1 time per tooth per five year period Crown replacement: 1 time five year period from initial or supplemental placement.	Not Covered
Implants Procedures	6 month waiting period. 1 time per tooth per five year period	6 month waiting period. 1 time per tooth per five year period	Not Covered
Relines and Rebases Dentures	Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months.	Relining and Rebasing Dentures: 6 months after initial installation and 1 time per consecutive 12 months.	Not Covered
Occlusal Guards	Covered if prescribed to control habitual grinding	Covered if prescribed to control habitual grinding	Covered as a basic service
Orthodontia			
Orthodontia Co-Insurance	50% - No age limit	0% Not Covered	0% Not Covered

*The Annual Maximum Benefit is the maximum amount the plan will pay each calendar year. It is a combined annual maximum for network and out-of-network benefit services.

*Women who are pregnant and have gum disease, individuals with diabetes and gum disease, as well as individuals at risk for infective endocarditis, or other at-risk conditions such as renal failure, immune suppressed systems due to chemotherapy and/or radiation, organ transplant, or stem cell transplant may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.

*Out-of-network reimbursement has changed from 90th UCR to the PPO fee schedule.

Please refer to the Delta Dental Certificate of Coverage for a detail description of the plan benefits.