

# Summary of Dental Plan Benefits

## USD #202 - TURNER - High Option

### Group #50033

	Benefit % Paid				
	Delta Dental PPO	Delta Dental Premier	Out-of-Network		
<b>MAXIMUM BENEFIT(S) PER PERSON:</b> The Maximum Benefit for all Covered Services, excluding Diagnostic and Preventive Services, including Implant Services, for each Enrollee in any one Calendar Year is: <b>One Thousand Five Hundred Dollars (\$1,500.00).</b>	100%	100%	100%	<b>DIAGNOSTIC &amp; PREVENTIVE</b> (Not Subject to Deductible or Maximum)	<b>Diagnostic:</b> Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: <ul style="list-style-type: none"> <li>• <u>Oral evaluations</u> - two (2) times per Calendar Year.</li> <li>• <u>Bitewing x-rays</u> - bitewings two (2) times per Calendar Year for dependents under age eighteen (18) and once (1) each twelve (12) months for adults age eighteen (18) and over.</li> <li>• <u>Full mouth or panoramic x-rays</u> - once (1) each five (5) years.</li> </ul>
	100%	100%	100%		
The Maximum Benefit for Orthodontic Services for each Enrollee is: <b>One Thousand Dollars (\$1,000.00)</b> during such person's lifetime. Payment for the Orthodontic Services shall not be included in determining the Maximum Benefit for each Calendar Year.	80%	80%	80%	<b>BASIC</b> (Subject to Deductible)	<b>Ancillary:</b> Provides for one (1) emergency examination per plan year by the Dentist for the relief of pain.
	80%	80%	80%		
<b>DEDUCTIBLE LIMITATIONS:</b> Coverage for Diagnostic and Preventive Services are not subject to any Deductible amount. For all other covered benefits, the Calendar Year Deductible is: <b>\$50x3</b>	80%	80%	80%	<b>Regular Restorative:</b> Provides amalgam (silver) restorations; composite (white) resin restorations on all teeth; and stainless steel crowns for dependents under age twelve (12).	<b>Endodontics:</b> Includes procedures for root canal treatments and root canal fillings. When covered, payment for root canal therapy is limited to only once (1) in any twenty-four (24) month period, per tooth.
	80%	80%	80%		
<b>ELIGIBLE CHILDREN AGES:</b> Children are eligible for coverage to age <b>twenty-six (26)</b> .	80%	80%	80%	<b>MAJOR</b> (Subject to Deductible)	<b>Special Restorative:</b> When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
	50%	50%	50%		
	50%	50%	50%	<b>ORTHODONTICS</b> (Subject to Deductible)	<b>Orthodontics:</b> Includes orthodontic appliances and treatment, interceptive and corrective, for dependent children under age nineteen (19).
	50%	50%	50%		

*This is a summary of benefits only and does not bind Delta Dental of Kansas to any coverage. Subscribers are encouraged to familiarize themselves with the details of their individual plan benefits. Subscribers are responsible for any required copayments, deductibles, or fees for services not covered by their plan at the time services are performed. Please refer to the Description of Dental Care Coverage ("Benefits Booklet") for complete coverage information, including but not limited to any applicable exclusions and limitations. Coverage as described in the employer group's dental benefits contract with Delta Dental of Kansas is binding on all parties and supersedes all other written or oral communications.*