

Summary of Dental Plan Benefits

USD #202 - TURNER - Low Option

Group #50033

MAXIMUM BENEFIT(S) PER PERSON: The Maximum Benefit for all Covered Services, excluding Diagnostic and Preventive Services, for each Enrollee in any one Calendar Year is: One Thousand Dollars (\$1,000.00).	Benefit % Paid				
	Delta Dental PPO	Delta Dental Premier	Out-of-Network		
DEDUCTIBLE LIMITATIONS: Coverage for Diagnostic and Preventive Services are not subject to any Deductible amount. For all other covered benefits, the Calendar Year Deductible is: \$50x3	100%	100%	100%	DIAGNOSTIC & PREVENTIVE (Not Subject to Deductible or Maximum)	
	100%	100%	100%	Diagnostic:	Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: <ul style="list-style-type: none"> • <u>Oral evaluations</u> – two (2) times per Calendar Year. • <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. • <u>Full mouth or panoramic x-rays</u> – once (1) each five (5) years.
ELIGIBLE CHILDREN AGES: Children are eligible for coverage to age twenty-six (26) .	80%	80%	80%	Preventive:	Provides for the following: <ul style="list-style-type: none"> • <u>Prophylaxis</u> (Cleanings) – two (2) times per Calendar Year. • <u>Topical Fluoride</u> – two (2) times per Calendar Year for dependent children under age nineteen (19). • <u>Space Maintainers</u> – for dependent children under age fourteen (14) and only for premature loss of primary molars. • <u>Sealants</u> – once (1) per tooth per lifetime for dependent children under age sixteen (16) when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.
	80%	80%	80%	BASIC (Subject to Deductible)	
				Ancillary:	Provides for one (1) emergency examination per plan year by the Dentist for the relief of pain.
				Oral Surgery:	Provides for extractions and other oral surgery including pre and post-operative care.
				Regular Restorative:	Provides amalgam (silver) restorations; composite (white) resin restorations on all teeth; and stainless steel crowns for dependents under age twelve (12).
				MAJOR (Subject to Deductible)	
				Endodontics:	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.
				Periodontics:	a. Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is not counted toward the frequency limitation for prophylaxis cleanings. b. Surgical periodontal procedures.
				Special Restorative:	When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
				Prosthodontics:	a. Includes bridges, partial and complete dentures. b. Repairs and adjustments of bridges and dentures.
				ORTHODONTICS (Subject to Deductible)	
				Orthodontics:	Orthodontic appliances and treatment.

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.