Amherst EVSD

2024-2025 Insurance Rates

(posted to www.amherstk12.org)

Delta Dental Plans and EyeMed Vision Plan

Delta Dental PPO Plan All Full-Time Employees			
Rates effective 7/1/2024	**Total Monthly LERC-MMO**	**COBRA +2%**	**Employee Share - 33%**
Single	**39.95**	**40.75**	**13.18**
Family	**109.14**	**111.32**	**36.02**

Delta Dental EPO Plan All Full-Time Employees			
Rates effective 7/1/2024	**Total Monthly LERC-MMO**	**COBRA +2%**	**Employee Share - 33%**
Single	**22.69**	**23.14**	**7.49**
Family	**61.74**	**62.97**	**20.37**

EyeMed Vision All Employees			
Rates effective 7/1/2024	**Total Monthly LERC-MMO**	**COBRA +2%**	**Employee Share - 20%**
Full-Time			
Single	**3.07**	**3.13**	**0.61**
Family	**8.44**	**8.61**	**1.69**
Part-Time*			50%
Single	**3.07**	**3.13**	**1.54**
Family	**8.44**	**8.61**	**4.22**

*Rates shown are based on 0.5 FTE. Exact part-time rates deteremined by contracted hours.

COBRA - 2% premium added to Health/Dental/Vision Rates

MEDICAL MUTUAL®

EyeMed

LERC #882859

Vision Care Services	In-Network Member Cost	Out-of Network Reimbursement
Exam with Dilation as necessary	$15 Copay	Up to $15
Contact Lens Fit & Follow-up		
Standard contact lens fit & follow-up	Up to $55	N/A
Premium contact lens fit & follow-up	10% off retail price	N/A
Frames	$0 Copay; 20% off balance over $100 allowance	Up to $30
Standard Plastic Lenses		
Single vision	$15 Copay	Up to $10
Bifocal	$15 Copay	Up to $20
Trifocal	$15 Copay	Up to $30
Lenticular	$15 Copay	Up to $40
Standard Progressive Lens	$80 Copay	Up to $20
Premium Progressive Lens[1]	$80 Copay;20% off retail less $120 allowance	Up to $20
Lens Options		
UV Treatment	$15	N/A
Tint (solid and gradient)	$15	N/A
Standard plastic scratch coating	$15	N/A
Standard Polycarbonate - adults	$40	N/A
Standard polycarbonate - kids under 19	$40	N/A
Standard anti-reflective coating	$45	N/A
Premium anti-reflective coating	20% off retail price	N/A
Polarized	20% off retail price	N/A
Other add-ons and services	20% off retail price	N/A
Contact Lenses (contact lens allowance includes materials only. Any remaining balance for contact lenses may be used within the same benefit frequency)		
Conventional	$15 Copay; 15% off balance over $100	Up to $40
Disposable	$15 Copay; 100% of balance over $100	
Medically necessary	$15 Copay; 5% off balance over $200	Up to $40 Up to $75
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	
Frequency		
Examination	Once every 12 months	
Lenses or contact lenses	Once every 12 months	
Frames	Once every 12 months	
Laser Vision Correction	Once per lifetime	

ADDITIONAL DISCOUNTS:

- 40% off complete pair of prescription eyeglasses*
- 20% off non-prescription sunglasses*
- 20% off remaining balance beyond plan coverage*

You're on the ACCESS network. For a complete list of providers near you, use our Provider Locator on EyeMed.com or call 1.877.226.1115. For LASIK providers, call 1.800.988.4221.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

These discounts are for in-network providers only

For the period 1/1/2024-12/31/2024.

1Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. All providers are not required to carry all brands at all levels

No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonia lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. See the Provider Locator to find participating providers who offer the discounted rate.

DELTA DENTAL®

Delta Dental EPO™
Summary of Dental Plan Benefits
For Group# 1555-0192
Lake Erie Regional Council
Amherst Schools

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate.

Control Plan – Delta Dental of Ohio

Benefit Year – January 1 through December 31

Covered Services - Please refer to the Member Copayment Schedule for a list of Covered Services and Copayments. When more than one treatment option is available, the least expensive treatment is the one covered. Copayments will be reviewed annually for adjustment. Procedure codes are subject to change to reflect current American Dental Association (ADA) procedure codes. Any changes to the Member Copayment Schedule will be effective any January 1.

You must receive dental care from a Delta Dental EPO Dentist in order to receive Benefits. If you receive services from a Non-EPO Dentist, you will be responsible for paying for those services, unless that dental care is Emergency Dental Treatment. If you require Emergency Dental Treatment and your EPO Dentist is not available, you may obtain treatment from any Dentist. You are responsible for paying for the Emergency Dental Treatment. Delta Dental will reimburse you up to the Maximum Payment for Emergency Dental Treatment.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year for people age 18 and under.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any five-year period.
- Sealants are payable once per tooth per lifetime for first permanent molars for people age eight and under and second permanent molars for people age 13 and under. The surface must be free from decay and restorations.
- Composite resin (white) restorations are payable on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants and implant related services are not Covered Services.
- Crowns over implants and their related services are not Covered Services.
- Occlusal guards and occlusal adjustments are not a Covered Service.
- Comprehensive orthodontic treatment is a Covered Service.

Maximum Payment – $125 per person total per Benefit Year for Emergency Dental Treatment from a Non-EPO Dentist. There is no annual or lifetime maximum on treatment received from an EPO Dentist.

Deductible – None.

Waiting Period – Employees who are eligible for dental benefits are covered as defined by Amherst Schools.

Eligible People – As defined by Amherst Schools.

Also eligible are your Spouse and your Children to the end of the month in which they turn 26, including your Children who are married, who no longer live with you, who are not your Dependents for Federal income tax purposes, and/or who are not permanently disabled.

Enrollees and their Dependents choosing either dental plan are required to remain enrolled for a period of 12 months. Should an Enrollee or Dependent choose to drop dental coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may enroll if the Enrollee is enrolled (excluding COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if such change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Enrollees under This Plan.

Benefits will cease on the last day of the month in which the employee is terminated.

Delta Dental Plan EPO 32
MEMBER COPAYMENT SCHEDULE

CDT-2022*

DIAGNOSTIC SERVICES

CLINICAL ORAL EVALUATIONS

D0120	Oral examination, periodic	$0
D0140	Oral examination, limited, problem focused (emergency)	$0
D0145	Oral evaluation for patients under age 3 and counseling with primary caregiver	$0
D0150	Oral examination, comprehensive evaluation	$0
D0160	Oral examination, detailed and extensive evaluation, problem focused, by report	$0
D0180	Oral examination, comprehensive periodontal evaluation	$0
D0190	Screening of a patient	$0

When any exam is performed by a specialist, there is a $12 copayment.

RADIOGRAPHS

D0210	Intraoral, complete series (includes bitewings)	$0
D0220	Intraoral, periapical first film	$0
D0230	Intraoral, periapical each addt'l film	$0
D0240	Intraoral, occlusal	$0
D0270	Bitewing, 1 film	$0
D0272	Bitewing, 2 films	$0
D0273	Bitewing, 3 films	$0
D0274	Bitewing, 4 films	$0
D0277	Bitewing, vertical, 7 to 8 films	$0
D0330	Panoramic film	$0

TESTS & LABORATORY

D0460	Pulp vitality	$0
D0486	Accession of brush biopsy sample, microscopic exam, prep and written report	$0
D0999	Diagnostic procedure - unspecified, by report	$0

PREVENTIVE

DENTAL PROPHYLAXIS (cleaning)

D1110	Prophylaxis – adult	$0
D1120	Prophylaxis – child	$0

FLUORIDE TREATMENT

D1206	Topical fluoride varnish - child	$0
D1208	Topical application of fluoride	$0

OTHER PREVENTIVE SERVICES

D1351	Sealant (per tooth)	$0
D1353	Sealant repair (per tooth)	$0

SPACE MAINTAINERS

D1510	Fixed, unilateral – per quadrant	$0
D1516	Fixed, bilateral, maxillary	$0
D1517	Fixed, bilateral, mandibular	$0
D1520	Removable, unilateral – per quadrant	$0
D1526	Removable, bilateral, maxillary	$0
D1527	Removable, bilateral, mandibular	$0
D1551	Recement or rebond bilateral – maxillary	$0
D1552	Recement or rebond bilateral – mandibular	$0
D1553	Recement or rebond – unilateral – per quadrant	$0
D1556	Removal, fixed unilateral – per quadrant	$0
D1557	Removal, fixed bilateral – maxillary	$0
D1558	Removal, fixed bilateral - mandibular	$0
D1575	Distal shoe – fixed, unilateral – per quadrant	$0

RESTORATIVE PROCEDURES

AMALGAM RESTORATIONS

D2140	1 surface	$31
D2150	2 surfaces	$38
D2160	3 surfaces	$46
D2161	4 or more surfaces	$56

RESIN RESTORATIONS

D2330	1 surface, anterior	$39
D2331	2 surfaces, anterior	$48
D2332	3 surfaces, anterior	$57
D2335	Involving incisal angle or 4 or more surfaces, anterior	$72
D2390	Crown, anterior	$60
D2391	1 surface, posterior	$45
D2392	2 surfaces, posterior	$59
D2393	3 surfaces, posterior	$72
D2394	4 or more surfaces, posterior	$88

INLAY/ONLAY RESTORATIONS[1]

D2510	Inlay, metallic, 1 surface	$252
D2520	Inlay, metallic, 2 surfaces	$265
D2530	Inlay, metallic, 3 or more surfaces	$279
D2542	Onlay, metallic, 2 surfaces	$292
D2543	Onlay, metallic, 3 surfaces	$302
D2544	Onlay, metallic, 4 or more surfaces	$313
D2610	Inlay, porcelain/ceramic, 1 surface	$256
D2620	Inlay, porcelain/ceramic, 2 surfaces	$268
D2630	Inlay, porcelain/ceramic, 3 or more surfaces	$281
D2642	Onlay, porcelain/ceramic, 2 surfaces	$311
D2643	Onlay, porcelain/ceramic, 3 surfaces	$321
D2644	Onlay, porcelain/ceramic, 4 or more surfaces	$332
D2650	Inlay, resin-based, 1 surface	$220
D2651	Inlay, resin-based, 2 surfaces	$232
D2652	Inlay, resin-based, 3 or more surfaces	$245
D2662	Onlay, resin-based, 2 surfaces	$257
D2663	Onlay, resin-based, 3 surfaces	$267
D2664	Onlay, resin-based, 4 or more surfaces	$277

CROWNS - SINGLE RESTORATION ONLY[1]

D2710	Resin (indirect)	$229
D2720	Resin with high noble metal	$317
D2721	Resin with predominantly base metal	$279
D2722	Resin with noble metal	$298
D2740	Porcelain/ceramic	$345
D2750	Porcelain fused to high noble metal	$327
D2751	Porcelain fused to predominantly base metal	$289
D2752	Porcelain fused to noble metal	$308
D2753	Porcelain fused to titanium and titanium alloys	$327
D2780	3/4 cast high noble metal	$303
D2781	3/4 cast predominantly base metal	$268
D2782	3/4 cast noble metal	$284
D2783	3/4 porcelain/ceramic	$337
D2790	Full cast high noble metal	$322
D2791	Full cast predominantly base metal	$284
D2792	Full cast noble metal	$303
D2794	Titanium	$322

OTHER RESTORATIVE SERVICES

D2910	Recement onlay or partial coverage restoration	$30
D2915	Recement cast or prefabricated post and core	$30
D2920	Recement crown	$30
D2930	Crown - prefabricated stainless steel, primary	$83
D2931	Crown - prefabricated stainless steel, permanent	$83
D2932	Crown - prefabricated resin	$95
D2933	Crown - prefabricated stainless steel with resin window	$111
D2940	Sedative filling	$33
D2950	Crown buildup (substructure) including any pins	$83
D2951	Pin retention - per tooth, in addition to restoration	$15
D2952	Post and core in addition to crown, indirectly fabricated	$111
D2954	Prefabricated post and core in addition to crown	$99
D2971	Addt'l procedures to construct new crown under existing partial denture	$65
D2980	Crown repair, by report	$70
D2981	Inlay repair	$70
D2982	Onlay repair	$70

ENDODONTICS

PULPOTOMY

D3220	Therapeutic pulpotomy	$48
D3221	Pulpal debridement, primary and permanent teeth	$46

ROOT CANAL THERAPY

D3310	Anterior (excludes final restoration)	$201
D3320	Premolar (excludes final restoration)	$239
D3330	Molar tooth (excludes final restoration)	$295
D3346	Retreatment, anterior	$220
D3347	Retreatment, premolar	$268
D3348	Retreatment, molar	$326

PERIAPICAL SERVICES

D3410	Apicoectomy/periradicular surgery - anterior	$173
D3421	Apicoectomy/periradicular surgery - premolar, first root	$186
D3425	Apicoectomy/periradicular surgery - molar, first root	$207
D3426	Apicoectomy/periradicular surgery - each additional root	$74
D3430	Retrograde filling - per root	$49

PERIODONTIC SERVICES

SURGICAL SERVICES

D4210	Gingivectomy or gingivoplasty – 4 or more teeth per quadrant	$117
D4211	Gingivectomy or gingivoplasty – 1 to 3 teeth per quadrant	$82
D4240	Gingival flap procedure, includes root planing – 4 or more teeth per quadrant	$159
D4241	Gingival flap procedure, includes root planing, 1 to 3 teeth per quadrant	$111
D4245	Apically positioned flap	$185
D4249	Clinical crown lengthening	$141
D4260	Osseous surgery – 4 or more teeth per quadrant	$233
D4261	Osseous surgery – 1 to 3 teeth per quadrant	$148

NON-SURGICAL SERVICES

D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant	$72
D4342	Periodontal scaling and root planing – 1 to 3 teeth per quadrant	$45
D4346	Scaling in the presence of inflammation	$0
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$51
D4910	Periodontal maintenance	$46

PROSTHODONTICS (Removable)[2]

COMPLETE DENTURES

D5110	Denture - complete, maxillary	$120
D5120	Denture - complete, mandibular	$120
D5130	Denture - immediate, maxillary	$432
D5140	Denture - immediate, mandibular	$432

PARTIAL DENTURES

D5211	Maxillary, resin base	$332
D5212	Mandibular, resin base	$332
D5213	Maxillary, cast metal framework with resin denture base	$445
D5214	Mandibular, cast metal framework with resin denture base	$445
D5221	Maxillary, immediate, resin base	$365
D5222	Mandibular, immediate, resin base	$365
D5223	Maxillary, immediate, cast metal framework with resin denture base	$490
D5224	Mandibular, immediate, cast metal framework with resin denture base	$490
D5225	Maxillary partial denture – flexible base (including retentive/clasping	$452

	materials, rests, and teeth)	
D5226	Mandibular partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	$452
D5227	Immediate maxillary partial denture – flexible base (including any clasps, rests, and teeth)	$496
D5228	Immediate mandibular partial denture – flexible base (including any clasps, rests, and teeth)	$496
D5282	Removable unilateral partial denture – one-piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	$223
D5283	Removable unilateral partial denture – one-piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	$223
D5284	Removable unilateral partial denture – one-piece flexible base (including retentive/clasping materials, rests, and teeth) – per quadrant	$223
D5286	Removable unilateral, one-piece resin (including retentive/clasping materials, rests, and teeth) – per quadrant	$223

ADJUSTMENT TO DENTURES

D5410	Complete, maxillary	$25
D5411	Complete, mandibular	$25
D5421	Partial, maxillary	$25
D5422	Partial, mandibular	$25

REPAIRS TO COMPLETE DENTURES

D5511	Repair broken complete denture base, mandibular	$58
D5512	Repair broken complete denture base, maxillary	$58
D5520	Replace missing or broken teeth (each tooth)	$48

REPAIRS TO PARTIAL DENTURES

D5611	Repair resin partial denture base, mandibular	$58
D5612	Repair resin partial denture base, maxillary	$58
D5621	Repair cast partial framework, mandibular	$83
D5622	Repair cast partial framework, maxillary	$83
D5630	Repair or replace broken clasp (per tooth)	$83
D5640	Replace broken tooth (each)	$48
D5650	Add tooth to existing partial denture	$61
D5660	Add clasp to existing partial denture (per tooth)	$83
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$249
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$249

DENTURE REBASE PROCEDURES

D5710	Complete maxillary denture	$159
D5711	Complete mandibular denture	$159
D5720	Maxillary partial denture	$162
D5721	Mandibular partial denture	$162
D5725	Rebase hybrid prosthesis	$1,546

DENTURE RELINE PROCEDURES

D5730	Complete maxillary, direct	$99
D5731	Complete mandibular, direct	$99
D5740	Maxillary partial, direct	$93
D5741	Mandibular partial, direct	$93
D5750	Complete maxillary, indirect	$130
D5751	Complete mandibular, indirect	$130
D5760	Maxillary partial, indirect	$130
D5761	Mandibular partial, indirect	$130
D5765	Soft liner for complete or partial removeable denture – indirect	$130

OTHER REMOVABLE PROSTHETIC SERVICES

D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	$148
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	$148
D5850	Tissue conditioning, maxillary	$64
D5851	Tissue conditioning, mandibular	$64
D5863	Overdenture, complete maxillary	$159
D5864	Overdenture, partial maxillary	$159
D5865	Overdenture, complete mandibular	$159
D5866	Overdenture, partial mandibular	$159

PROSTHODONTICS (Fixed)[1]

BRIDGE PONTICS (Per Unit)

D6210	Cast high noble metal	$300
D6211	Cast base metal	$286
D6212	Cast noble metal	$292
D6240	Porcelain fused to high noble metal	$313
D6241	Porcelain fused to base metal	$292
D6242	Porcelain fused to noble metal	$302
D6243	Porcelain fused to titanium and titanium alloys	$313
D6250	Resin with high noble metal	$288
D6251	Resin with base metal	$274
D6252	Resin with noble metal	$280

FIXED BRIDGE RETAINERS – INLAYS/ONLAYS

D6545	Retainer - cast metal for resin bonded fixed prosthesis	$87
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	$87
D6549	Retainer – resin for resin bonded fixed prosthesis	$87
D6600	Inlay, porcelain/ceramic, 2 surfaces	$287
D6601	Inlay, porcelain/ceramic, 3 or more surfaces	$296
D6602	Inlay, cast high noble metal, 2 surfaces	$279
D6603	Inlay, cast high noble metal, 3 or more surfaces	$292
D6604	Inlay, cast predominantly base metal, 2 surfaces	$252
D6605	Inlay, cast predominantly base metal, 3 or more surfaces	$265
D6606	Inlay, cast noble metal, 2 surfaces	$265
D6607	Inlay, cast noble metal, 3 or more surfaces	$279
D6608	Onlay, porcelain/ceramic, 2 surfaces	$231
D6609	Onlay, porcelain/ceramic, 3 or more surfaces	$301
D6610	Onlay, cast high noble metal, 2 surfaces	$224
D6611	Onlay, cast high noble metal, 3 or more surfaces	$292
D6612	Onlay, cast predominantly base metal, 2 surfaces	$252
D6613	Onlay, cast predominantly base metal, 3 or more surfaces	$265
D6614	Onlay, cast noble metal, 2 surfaces	$292
D6615	Onlay, cast noble metal, 3 or more surfaces	$302

BRIDGE RETAINERS – CROWNS

D6720	Resin with high noble metal	$317
D6721	Resin with base metal	$279
D6722	Resin with noble metal	$298
D6750	Porcelain fused to high noble metal	$327
D6751	Porcelain fused to base metal	$289
D6752	Porcelain fused to noble metal	$308
D6753	Porcelain fused to titanium and titanium alloys	$327
D6780	3/4 cast high noble metal	$317
D6781	3/4 cast base metal	$279
D6782	3/4 cast noble metal	$298
D6784	3/4 titanium and titanium alloys	$317
D6790	Full cast high noble metal	$322
D6791	Full cast base metal	$284
D6792	Full cast noble metal	$303

OTHER FIXED PROSTHETIC SERVICES

D6930	Recement fixed partial denture	$42
D6940	Stress breaker	$68

ORAL SURGERY

EXTRACTIONS (Simple)

D7111	Extraction, coronal remnants – primary tooth	$29
D7140	Extraction, erupted tooth or exposed root	$38

SURGICAL EXTRACTIONS

D7210	Surgical removal of erupted tooth	$76
D7220	Removal of impacted tooth – soft tissue	$92
D7230	Removal of impacted tooth – partially bony	$125
D7240	Removal of impacted tooth – completely bony	$146
D7241	Removal of impacted tooth – completely bony with complications	$184
D7250	Surgical removal of residual roots	$80

OTHER SURGICAL PROCEDURES

D7286	Biopsy of oral tissue – soft	$46
D7288	Brush biopsy	$35

ALVEOLOPLASTY (Surgical Preparation of Ridge for Dentures)

D7310	In conjunction with extractions, 4 or more teeth or spaces per quadrant	$73
D7311	In conjunction with extractions, 1 to 3 teeth or spaces per quadrant	$45
D7320	Not in conjunction with extractions, 4 or more teeth or spaces per quadrant	$80
D7321	Not in conjunction with extractions, 1 to 3 teeth or spaces per quadrant	$48

EXCISION OF BONE TISSUE

D7471	Removal of lateral exostosis	$143
D7472	Removal of torus palatinus	$143
D7473	Removal of torus mandibularis	$143

SURGICAL INCISION

D7510	Incision and drainage of abscess – intraoral soft tissue	$49
D7922	Placement of intra-socket biological dressing to aid in homeostasis or clot stabilization – per site	$0

OTHER REPAIR PROCEDURES

D7961	Buccal/labial frenectomy (frenulectomy)	$89
D7962	Lingual frenectomy (frenulectomy)	$89
D7963	Frenuloplasty	$89

ADJUNCTIVE GENERAL SERVICES

UNCLASSIFIED TREATMENT

D9110	Palliative (emergency) treatment of dental pain – minor procedure	$30

PROFESSIONAL CONSULTATION

D9310	Consultation by dentist other than requesting dentist	$20

PROFESSIONAL VISITS

D9440	Office visit after regularly scheduled hours	$0

MISCELLANEOUS SERVICES

D9997	Dental case management – patients with special health care needs	$0
D9999	Unspecified, by report	$50

ORTHODONTICS[3]

RECORDS (solely for orthodontic purposes)

D0340	Cephalometric film	$0
D0350	Oral/facial photographic images	$0
D0470	Diagnostic casts	$0

COMPREHENSIVE ORTHODONTIC TREATMENT

D8070	Transitional dentition	$2,100
D8080	Adolescent dentition	$2,100
D8090	Adult dentition (to age 19)	$2,100

[1]Porcelain/ceramic on molars is considered optional treatment.

[2]Includes any adjustments for six months.

[3]Orthodontic Benefits include the initial examination, diagnosis, consultation, initial banding, monthly active treatment, de-banding, and the retention phase of treatment. The retention phase includes the initial construction, placement, and adjustments to retainers and office visits.

*Note – The Member Copayment Schedule reflects current CDT codes and fees. These may be updated at a future date, as necessary. Please contact Delta Dental for the most up-to-date fees and codes.

DELTA DENTAL®

Delta Dental PPO™ (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 1555-0191
Lake Erie Regional Council
Amherst Schools

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Ohio

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	100%	80%	80%
Endodontic Services – root canals	100%	80%	80%
Periodontic Services – to treat gum disease	100%	80%	80%
Oral Surgery Services – extractions and dental surgery	100%	80%	80%
Other Basic Services – misc. services	100%	80%	80%
Relines and Repairs – to prosthetic appliances	100%	80%	80%
Major Services			
Major Restorative Services – crowns	60%	60%	60%
Prosthodontic Services – bridges, implants, dentures, and crowns over implants	60%	60%	60%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	through age 18 and under	through age 18 and under	through age 18 and under

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable once per calendar year for people age 18 and under.
- Bitewing X-rays are payable twice per calendar year. Full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any three-year period.
- Sealants are payable once per tooth per three-year period for first and second permanent molars for people age 13 and under. The surface must be free from decay and restorations.
- Composite resin (white) restorations are payable on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.

- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – **Delta Dental PPO™ Dentist -** $2,000 per person total per Benefit Year on all services except orthodontic services. $1,000 per person total per lifetime on orthodontic services.

Delta Dental Premier® Dentist or Nonparticipating Dentist - $1,500 per person total per Benefit Year on all services except orthodontic services. $1,000 per person total per lifetime on orthodontic services.

These are not separate maximums by type of dentist.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by your Dentist to Delta Dental.

Deductible – None.

Waiting Period – Enrollees who are eligible for Benefits are covered as defined by Amherst Schools.

Eligible People – As defined by Amherst Schools.

Also eligible are your Spouse and your Children to the end of the month in which they turn 26, including your Children who are married, who no longer live with you, who are not your Dependents for Federal income tax purposes, and/or who are not permanently disabled.

Enrollees and their Dependents choosing either dental plan are required to remain enrolled for a period of 12 months. Should an Enrollee or Dependent choose to drop dental coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may enroll if the Enrollee is enrolled (excluding COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if such change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Enrollees under This Plan.

Benefits will cease on the last day of the month in which the employee is terminated.