

| St. Joseph School District <u>BASE PLAN</u> | Delta Dental PPO™ Network | Delta Dental Premier® Network | Out-of-Network |
|--|---|---|---|
| | Based on applicable PPO Maximum Plan Allowance - No balance billing | Based on applicable Premier Maximum Plan Allowance - No balance billing | Based on applicable Maximum Plan Allowance for Out-of-Network dentist - Balance billing is possible |
| Preventive services <ul style="list-style-type: none"> • Bitewing x-rays, two sets per calendar year • Emergency palliative treatment • Full mouth x-rays, once in any 36-month period • Oral Examinations, twice in any calendar year • Periapical x-rays, as required • Prophylaxis (cleanings), twice in any calendar year • Sealants for dependent children under age 14, once in 3 years • Space maintainers for dependent children under age 16, initial appliance only • Topical fluoride treatments for dependent children under age 19, twice in any benefit period | 100% | 100% | 100% |
| Basic services <ul style="list-style-type: none"> • Fillings, including composite fillings covered on all teeth • Endodontics • Periodontal maintenance, twice in any calendar year (subject to your prophylaxis frequency limitation) • Non-Surgical Periodontics • Surgical Periodontics • Simple extractions • Surgical extractions • Other oral surgery • Stainless steel crowns, once in 5 years • General Anesthesia | 80% | 60% | 60% |
| Major services <ul style="list-style-type: none"> • Bridge repairs & recement • Bridges, once in 5 years • Crown repairs & recement • Crowns, Inlays, Onlays, once in 5 years • Denture repairs & adjustments • Dentures, once in 5 years • Implants, as well as bone grafts, are a covered benefit. Limited to once in 5 years. | 50% | 40% | 40% |
| Orthodontia Orthodontia for dependent children under age 19 | 50% up to \$1,000 Lifetime Maximum | 50% up to \$1,000 Lifetime Maximum | 50% up to \$1,000 Lifetime Maximum |
| Calendar year deductible (Applied to Basic and Major services) | \$50 per person | \$50 per person | \$50 per person |
| Calendar year maximum (Applied to Preventive, Basic and Major services) | \$1,000 per person | \$1,000 per person | \$1,000 per person |
| Dependent age limit: End of the calendar year following 26 th birthday | Monthly rates Coverage tier Employee \$26.45 Employee & spouse \$50.40 Employee & child(ren) \$66.19 Family \$100.10 | | |

This is intended to be a summary only. If a discrepancy occurs the Summary Plan Document will govern. Please refer to your Summary Plan Description (SPD) for a more complete listing of services including plan limitations and exclusions. Orthodontic treatment in progress may be covered. Benefits provided by the prior carrier will be subtracted from the lifetime maximum available from Delta Dental.