DELTA DENTAL®

EHB Certified Silver Plan

Pediatric Essential Health Benefits (EHB) included in plan

For individuals age 18 and under

Delta Dental PPO (Point-of-Service)	IN NETWORK		OUT OF NETWORK	WAITING PERIODS
	Delta Dental PPO™ dentist	Delta Dental Premier® dentist	Nonparticipating dentist	
	Plan pays	Plan pays	Plan pays	
DIAGNOSTIC AND PREVENTIVE SERVICES				
Diagnostic and preventive services—exams, cleanings, fluoride and space maintainers	100%	100%	100%	None
Brush biopsy—to detect oral cancer	100%	100%	100%	None
Emergency palliative treatment—to temporarily relieve pain	100%	100%	100%	None
Radiographs—X-rays	100%	100%	100%	None
Sealants—to prevent decay of permanent teeth	100%	100%	100%	None
BASIC SERVICES				
Minor restorative services—fillings and crown repair	80%	60%	60%	None
Oral surgery services—extractions and dental surgery	80%	60%	60%	None
Endodontic services—root canals	80%	60%	60%	None
Periodontic services—to treat gum disease	80%	60%	60%	None
Relines and repairs—prosthetic appliances	80%	60%	60%	None
Other basic services—miscellaneous services	80%	60%	60%	None
MAJOR SERVICES				
Prosthodontic services—bridges, dentures and crowns over implants	50%	50%	50%	None
Major restorative services—crowns	50%	50%	50%	None

DELTA DENTAL®

EHB Certified Silver Plan

Non-EHB covered services included in plan

For individuals 19 years of age or older, or individuals age 18 and under seeking non-EHB covered services

Delta Dental PPO (Point-of-Service)	IN NETWORK		OUT OF NETWORK	WAITING PERIODS
	Delta Dental PPO™ dentist	Delta Dental Premier® dentist	Nonparticipating dentist	
	Plan pays	Plan pays	Plan pays	
DIAGNOSTIC AND PREVENTIVE SERVICES				
Diagnostic and preventive services—exams, cleanings, fluoride and space maintainers	100%	80%	80%	None
Brush biopsy—to detect oral cancer	100%	80%	80%	None
Emergency palliative treatment—to temporarily relieve pain	100%	80%	80%	None
Radiographs—X-rays	100%	80%	80%	None
BASIC SERVICES				
Minor restorative services—fillings and crown repair	60%	50%	50%	6 months
Endodontic services—root canals	60%	50%	50%	6 months
Periodontic services—to treat gum disease	60%	50%	50%	6 months
Oral surgery services—extractions and dental surgery	60%	50%	50%	6 months
Periodontal maintenance—cleanings following periodontal therapy	60%	50%	50%	6 months
Relines and repairs—prosthetic appliances	60%	50%	50%	6 months
Other basic services—miscellaneous services	60%	50%	50%	6 months
MAJOR SERVICES				
Major restorative services—crowns	50%	50%	50%	12 months
TMD treatment—treatment of the disorder of the temporomandibular joint, including related films	50%	50%	50%	12 months
Prosthodontic services—bridges, dentures and crowns over implants	50%	50%	50%	12 months

Stay in network and save!

You can go to any licensed dentist, but you generally will save money if you go to a dentist who participates in one of our two networks—Delta Dental PPO or Delta Dental Premier. That's because Delta Dental has established maximum approved fees for nearly all dental services, and participating dentists agree to accept the maximum approved fee as full payment for those services. If the dentist's fee is higher than Delta Dental's, he or she cannot charge you the difference. This means you are responsible only for your copayments and deductibles, if any, when you visit a Delta Dental participating dentist.

What if I go to a nonparticipating dentist?

If you go to a dentist who does not participate in Delta Dental PPO or Delta Dental Premier, you will still be covered, but you may have to pay more. The percentages shown above 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 and you are responsible for the difference. We will pay you directly and you will be responsible for paying the dentist whatever he or she charges. You may also have to submit your own claims.

EHB covered services

EHB covered services include covered services to individuals age 18 and under that are considered Essential Health Benefits as defined by the Patient Protection and Affordable Care Act.

In-network annual out-of-pocket maximum for EHB covered services

An annual out-of-pocket maximum is the maximum amount that you or an eligible person will pay for EHB covered services throughout a benefit year. The in-network annual out-of-pocket maximum for EHB covered services shall be $400 per benefit year if this policy covers one eligible person age 18 and under, or $800 per benefit year if this policy covers two or more eligible persons age 18 and under. Any coinsurance, copayments, deductibles or other out-of-pocket expenses paid by an eligible person for in-network EHB covered services shall count toward that in-network annual out-of-pocket maximum. The in-network annual out-of-pocket maximum will not include any amounts paid for the following: (i) premiums; (ii) non-covered services; (iii) out-of-network dentists; (iv) coinsurance, copayments, deductibles or other out-of-pocket expenses for services other than EHB covered services; or (v) coinsurance, copayments, deductibles or other out-of-pocket expenses for EHB covered services provided to individuals 19 years of age and older. Once your applicable in-network annual out-of-pocket maximum is reached for the benefit year, all in-network EHB covered services provided to an eligible person will be covered at 100 percent of the maximum approved fee.

Out-of-network annual out-of-pocket maximum for EHB covered services

There is no annual out-of-pocket maximum for out-of-network EHB covered services. Eligible persons will be responsible for all copayments, deductibles and other out-of-pocket expenses associated with all out-of-network EHB covered services provided to eligible persons throughout the benefit year.

Deductible for EHB covered services

The deductible is $50 per individual per benefit year, limited to a maximum of $150 per family per benefit year. The deductible does not apply to exams, cleanings, fluoride, space maintainers, emergency palliative treatment, brush biopsy and sealants.

Annual and lifetime maximum for EHB covered services

There are no annual or lifetime maximum payments for EHB covered services under this policy.

Waiting period for EHB covered services

There are no waiting periods for eligible persons age 18 and under seeking EHB covered services.

Non-EHB covered services

Non-EHB covered services include all covered services that are not Essential Health Benefits as defined by the Patient Protection and Affordable Care Act.

Maximum payment for non-EHB covered services

$1,000 per person total per calendar year on all non-EHB covered services. $300 per person total per lifetime maximum for TMD treatment.

Annual out-of-pocket maximum payment for non-EHB covered services

An annual out-of-pocket maximum is the maximum amount that you or your eligible dependent will pay for covered services throughout a benefit year. There is no annual out-of-pocket maximum payment for non-EHB covered services. You will be responsible for all copayments, deductibles and other out-of-pocket expenses associated with all non-EHB covered services provided to you or your eligible dependent throughout the benefit year.

Deductible for non-EHB covered services

The deductible per individual per benefit year is $25, limited to a maximum of $75 per family per benefit year. The deductible does not apply to diagnostic and preventive services, brush biopsy, emergency palliative treatment and X-rays.

Waiting period for non-EHB covered services

Individuals 19 years of age or older, or individuals age 18 and under seeking non-EHB covered services, will be eligible for coverage for diagnostic and preventive, basic and major services in concordance with the applicable waiting periods set forth in the covered services chart above, measured from your or their date of coverage under this policy.

Eligible dependents enrolled after your date of enrollment will have their own waiting periods in accordance with the above.

NOTE: The above summary is a sample of benefits. Policies have exclusions and limitations that may limit coverage. For complete coverage details, please refer to your policy.

EXCLUSIONS: Charges or treatment for correction of congenital or developmental malformations or dentistry for aesthetic reasons; cosmetic surgery (including repairs to facings posterior to second bicuspid); treatment by anyone other than a licensed dentist or dental hygienist; veneers; prefabricated crowns as final restoration on permanent teeth and paste-type root canal fillings on permanent teeth; appliances, procedures and restorations for increasing vertical dimension, occlusion, tooth structure loss due to attrition, abrasion or erosion, or for periodontal splinting; lost, missing or stolen appliances; services not in the policy.

LIMITATIONS: Coverage for services may be limited based on the age of the person receiving services; coverage for certain services may be limited to maximum number of occurrences during a specified time period (such as two times per year or one time every three years); coverage for general anesthesia and/or intravenous sedation, sealants, prosthodontics (implants), orthodontic services, space maintainers and temporomandibular disorders (TMD) is limited.