



Delta Dental PPO Silver Family

Pediatric Essential Health Benefits (EHB) Included in Plan (FOR INDIVIDUALS UNDER THE AGE OF 21)

Welcome to Delta Dental—the Dental Benefits Expert

We are the oldest and largest dental carrier in the Commonwealth, and have one of the largest PPO dentist networks in the state and across the country. Dental is all we do, so take a look at what we have to offer.

This benefit summary provides an overview of the covered services for individuals and families.

Delta Dental PPO SM	Delta Dental PPO Dentist	Delta Dental Premier [®] Dentist	Nonparticipating Dentist	
	Plan Pays	Plan Pays*	Plan Pays*	
Annual deductible (per insured, does not apply to diagnostic and preventive and orthodontic services)	\$75	\$75	\$75	
Annual out-of-pocket maximum (per insured child/all children total)	\$350/\$700	Not applicable	Not applicable	WAITING PERIODS
DIAGNOSTIC & PREVENTIVE				
Diagnostic and preventive services —exams, cleanings, fluoride and space maintainers	100%	80%	80%	None
Emergency palliative treatment —to temporarily relieve pain	100%	80%	80%	None
Radiographs —all X-rays	100%	80%	80%	None
Sealants —to prevent decay of permanent teeth	100%	80%	80%	None
BASIC SERVICES				
Minor restorative services —fillings and crown repair	50%	50%	50%	None
Oral surgery services —extractions and dental surgery and services for the diagnosis and treatment of temporomandibular disorders	50%	50%	50%	None
Endodontic services —root canals	50%	50%	50%	None
Periodontic services —to treat gum disease	50%	50%	50%	None
Relines and repairs —to bridges and dentures	50%	50%	50%	None
Other basic services —miscellaneous services	50%	50%	50%	None
MAJOR SERVICES				
Prosthetic services —dentures and maxillofacial prosthetics	50%	50%	50%	None
Major restorative services —crowns	50%	50%	50%	None
ORTHODONTIC SERVICES				
Orthodontic services —medically necessary	50%	50%	50%	None

*When services are received from a Delta Dental Premier or 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 and you are responsible for that difference.

Please see last page for additional details.

Stay in network and save!

Regardless of your age, you can go to any licensed dentist, but you will save money if you go to a dentist who participates in our Delta Dental PPO network. Delta Dental PPO participating network dentists have agreed to fees that average approximately 30% below typical dental office prices. If the dentist's fee is higher than Delta Dental's allowed fee, 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 PPO participating dentist.

What if I go to a Delta Dental Premier or nonparticipating dentist?

If you go to a dentist who does not participate in Delta Dental PPO, you will still be covered, but most likely you will have to pay more. The amount Delta Dental pays may be less than what the out-of-network dentist (Delta Dental Premier and nonparticipating) charges, and you will be responsible for the difference. The coinsurance percentages you pay for services from out-of-network dentists (Delta Dental Premier and nonparticipating) are higher.



Delta Dental PPO Silver Family

Non-EHB Covered Services Included in Plan

(FOR INDIVIDUALS 21 YEARS OF AGE OR OLDER, OR INDIVIDUALS UNDER THE AGE OF 21 SEEKING NON-EHB COVERED SERVICES)

Delta Dental PPO SM	Delta Dental PPO Dentist	Delta Dental Premier [®] Dentist	Nonparticipating Dentist	
	Plan Pays	Plan Pays*	Plan Pays*	
Annual deductible (per insured, does not apply to diagnostic and preventive services)	\$50 per individual/\$150 total per family			WAITING PERIODS
Annual benefit maximum	\$750 maximum per individual			
DIAGNOSTIC & PREVENTIVE				
Diagnostic and preventive services —exams and cleanings	100%	75%	75%	None
Brush biopsy —to detect oral cancer	100%	75%	75%	None
Emergency palliative treatment —to temporarily relieve pain	100%	75%	75%	None
Radiographs —all X-rays	100%	75%	75%	None
BASIC SERVICES				
Minor restorative services —fillings and crown repair	50%	25%	25%	None
Denture repairs —repairs to partial or complete dentures	50%	25%	25%	None
Other basic services —miscellaneous services	50%	25%	25%	None
MAJOR SERVICES				
Oral surgery services —extractions and dental surgery	30%	15%	15%	12 months
Endodontic services —root canals	30%	15%	15%	12 months
Periodontic services —to treat gum disease	30%	15%	15%	12 months
Prosthetic services —bridges and dentures	30%	15%	15%	12 months
Major restorative services —crowns	30%	15%	15%	12 months

**When services are received from a Delta Dental Premier or 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 and you are responsible for that difference.*

Please see last page for additional details.



EHB COVERED SERVICES

EHB covered services include covered services to individuals under the age of 21 that are considered Essential Health Benefits as defined by the Patient Protection and Affordable Care Act.

IN-NETWORK OUT-OF-POCKET MAXIMUM FOR EHB COVERED SERVICES—An out-of-pocket maximum is the maximum amount that you or an eligible dependent will pay for covered services throughout a benefit year when you receive services from a participating dentist. For all in-network EHB covered services provided to EHB eligible persons, your maximum out-of-pocket payments under this certificate are \$350 per benefit year if this certificate covers one individual under the age of 21, or \$700 per benefit year if this certificate covers two or more individuals under the age of 21. Any copayments, deductibles or other out-of-pocket expenses paid by you for in-network EHB covered services provided to EHB eligible persons count toward that in-network out-of-pocket maximum. The in-network out-of-pocket maximum will not include any amounts paid for the following: (i) premiums; (ii) payments made by you for non-covered services; (iii) payments made by you to nonparticipating dentists; (iv) copayments, deductibles or other out-of-pocket expenses paid by you for services other than EHB covered services; or (v) copayments, deductibles or other out-of-pocket expenses paid by you for covered services provided to individuals 21 years of age and older. Once your applicable in-network out-of-pocket maximum is reached for the benefit year, all in-network EHB covered services provided to EHB eligible persons will be covered at 100 percent of the maximum approved fee.

OUT-OF-NETWORK OUT-OF-POCKET MAXIMUM FOR EHB COVERED SERVICES—There is no annual out-of-pocket maximum for EHB covered services received from Delta Dental Premier and nonparticipating (out-of-network) dentists. You will be responsible for all copayments, deductibles, balanced billing amounts and other out-of-pocket expenses associated with all out-of-network EHB covered services provided to you or your eligible dependent throughout the benefit year.

ANNUAL AND LIFETIME MAXIMUM PAYMENTS FOR EHB COVERED SERVICES—For all EHB covered services provided to individuals under the age of 21, there are no annual or lifetime maximum payments.

DEDUCTIBLES FOR EHB COVERED SERVICES—Deductible is waived for diagnostic and preventative services and orthodontics. There is a \$75 deductible for basic and major services.

WAITING PERIOD FOR EHB COVERED SERVICES—There are no waiting periods for individuals under the age of 21 seeking EHB covered services.

ELIGIBILITY—All persons allowed under the rules of the Kentucky Small Business Health Options Product Exchange. Benefits will cease on the last day of the month in which the employee is terminated.

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.

DEDUCTIBLE—\$50 deductible per person total per benefit year limited to a maximum deductible of \$150 per family per benefit year. The deductible does not apply to diagnostic and preventive services.

MAXIMUM PAYMENT—\$750 per person total per benefit year on all services.

DEPENDENT AGE LIMIT—Dependents are covered up to age 26.

WAITING PERIOD—There is a 12-month waiting period for major services.

ELIGIBILITY—All persons allowed under the rules of the Kentucky Small Business Health Options Product Exchange. Benefits will cease on the last day of the month in which the employee is terminated.

LIMITATIONS

- Oral exams (including evaluations by a specialist) are payable twice per calendar year. Limited oral evaluations for a specific problem or complaint are also payable twice in the same calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year. Two additional periodontal maintenance procedures are payable per calendar year for individuals with a documented history of periodontal disease. Full mouth debridement is payable once in a lifetime.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Composite resin (white) restorations on posterior (back) teeth are covered at the amalgam allowance.
- Porcelain and resin facings on bridges are covered services on posterior teeth.

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