DELTA DENTAL

Summary of Dental Plan Benefits

U S D #234 - FORT SCOTT - HIGH

Group #52697

Effective for January 1, 2018

Maximum Benefit(s) Per Person:

The Maximum Benefit payment for all Covered Services for each Enrollee in any one Calendar Year is: One Thousand Dollars ($1,000.00).

The Maximum Benefit for Orthodontic Services for each Enrollee is: One Thousand Dollars ($1,000.00) during such person's lifetime.
Payment for the Orthodontic Services shall not be included in determining the Maximum Benefit for each Calendar Year.

Deductible Limitations

Coverage for Diagnostic and Preventive Services is not subject to any deductible amount. For all other covered benefits, the Calendar Year Deductible is:

$50 x 3

Eligible Children Ages:

Children are eligible for coverage to age twenty-six (26).

Monthly Rates:

Employee:	$39.72
Employee + Spouse:	$79.83
Employee + Child(ren):	$84.39
Family:	$138.49

***Using a non-participating provider may result in higher out of pocket expenses. Refer to your benefit booklet for further information.**

Benefit % *Delta Dental PPO/Premier		
	DIAGNOSTIC & PREVENTIVE (Not Subject to Deductible)	
100%	**Diagnostic:**	Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: • Oral evaluations – once (1) each six (6) months. • Bitewing x-rays – bitewings once (1) each six months for dependents under age eighteen (18) and once each twelve (12) months for adults age eighteen (18) and over. • Full mouth x-rays or panoramic x-rays – once (1) each five (5) years.
100%	**Preventive:**	Provides for the following: • Prophylaxis (Cleanings) - once (1) each six (6) months. • Topical Fluoride – once (1) each six (6) months for dependent children under age sixteen (16). • Sealants – once (1) per tooth every three (3) years 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.
	BASIC (Subject to Deductible)	
50%	**Space Maintainers:**	Provided for dependent children under age sixteen (16) and only for premature loss of primary molars.
50%	**Ancillary:**	Provides for one (1) emergency examination per plan year by the Dentist for the relief of pain.
50%	**Oral Surgery:**	Provides for simple extractions.
50%	**Regular Restorative:**	Provides amalgam (silver) restorations; composite (white) resin restorations on all teeth; and stainless steel crowns for dependents under age twelve (12).
50%	**Periodontics:**	Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted towards the limitation for prophylaxis.
	MAJOR (Subject to Deductible)	
50%	**Oral Surgery:**	Provides for complex extractions and other oral surgery including pre and post-operative care.
50%	**Special Restorative:**	When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
50%	**Prosthodontics:**	Includes bridges, partial and complete dentures, including repairs and adjustments.
50%	**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.
50%	**Periodontics:**	Includes surgical periodontal procedures.
	ORTHODONTICS (Subject to Deductible)	
50%	**Orthodontics:**	Includes orthodontic appliances and treatment, interceptive and corrective, for dependent children under age eighteen (18).

This is a summary of benefits only and does not bind Delta Dental of Kansas to any coverage. Please refer to the Description of Dental Care Coverage for complete coverage information, including exclusions and limitations. Coverage as described in the employer group's Agreement to Provide Dental Benefits (contract) is binding on all parties and supersedes all other written or oral communications.

DELTA DENTAL

Summary of Dental Plan Benefits

U S D #234 - FORT SCOTT - LOW
Group #52698

Effective for January 1, 2018

Maximum Benefit(s) Per Person:
The Maximum Benefit payment for all Covered Services for each Enrollee in any one Calendar Year is: One Thousand Dollars ($1,000.00).

Deductible Limitations
Coverage for Diagnostic and Preventive Services is not subject to any deductible amount. For all other covered benefits, the Calendar Year Deductible is:

$50 x 3

Eligible Children Ages:
Children are eligible for coverage to age twenty-six (26).

Monthly Rates:

Employee:	$22.67
Employee + Spouse:	$43.94
Employee + Child(ren):	$53.97
Family:	$84.97

***Using a non-participating provider may result in higher out of pocket expenses. Refer to your benefit booklet for further information.**

Benefit % *Delta Dental PPO/Premier		
	DIAGNOSTIC & PREVENTIVE (Not Subject to Deductible)	
100%	**Diagnostic:**	Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: • Oral evaluations – once (1) each six (6) months. • Bitewing x-rays – bitewings once (1) each six months for dependents under age eighteen (18) and once each twelve (12) months for adults age eighteen (18) and over. • Full mouth x-rays or panoramic x-rays – once (1) each five (5) years.
100%	**Preventive:**	Provides for the following: • Prophylaxis (Cleanings) - once (1) each six (6) months. • Topical Fluoride – once (1) each six (6) months for dependent children under age sixteen (16). • Sealants – once (1) per tooth every three (3) years 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.
	BASIC (Subject to Deductible)	
50%	**Space Maintainers:**	Provided for dependent children under age sixteen (16) and only for premature loss of primary molars.
50%	**Ancillary:**	Provides for one (1) emergency examination per plan year by the Dentist for the relief of pain.
50%	**Oral Surgery:**	Provides for simple extractions.
50%	**Regular Restorative:**	Provides amalgam (silver) restorations; composite (white) resin restorations on all teeth; and stainless steel crowns for dependents under age twelve (12).
50%	**Periodontics:**	Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted towards the limitation for prophylaxis.
	MAJOR (Subject to Deductible)	
None	**Oral Surgery:**	Provides for complex extractions and other oral surgery including pre and post-operative care.
None	**Special Restorative:**	When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
None	**Prosthodontics:**	Includes bridges, partial and complete dentures, including repairs and adjustments.
None	**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.
None	**Periodontics:**	Includes surgical periodontal procedures.
	ORTHODONTICS (Subject to Deductible)	
None	**Orthodontics:**	Orthodontic appliances and treatment.

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