

Summary of Dental Plan Benefits

USD #202 - TURNER

Group #50033-0-2-0

Maximum Benefit(s) Per Person:

The Maximum Benefit for all Covered Services for each Enrollee in any one Calendar Year is: Seven Hundred Dollars (\$700.00).

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 nineteen (19) or to age twenty-four (24) if a full-time student.

Benefit % Paid

Delta Dental PPO	Delta Dental Premier	Non-participating
------------------	----------------------	-------------------

Delta Dental PPO	Delta Dental Premier	Non-participating	Benefit Description
100%	100%	100%	DIAGNOSTIC & PREVENTIVE (Not subject to Deductible)
100%	100%	100%	Diagnostic: Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: <ul style="list-style-type: none"> • <u>Oral evaluations</u> – once (1) each six (6) months. • <u>Bitewing x-rays</u> – bitewings once (1) each six (6) months for dependents under age eighteen (18) and once (1) each twelve (12) months for adults age eighteen (18) and over. • <u>Full mouth or panoramic x-rays</u> – once (1) each five (5) years.
100%	100%	100%	Preventive: Provides for the following: <ul style="list-style-type: none"> • <u>Prophylaxis</u> (Cleanings) - once (1) each six (6) months. • <u>Topical Fluoride</u> – once (1) each six (6) months for dependent children under age nineteen (19). • <u>Space Maintainers</u> – for dependent children under age fourteen (14) and only for premature loss of primary molars. • <u>Sealants</u> – once (1) per tooth per lifetime 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.
80%	80%	80%	BASIC (Subject to Deductible)
80%	80%	80%	Ancillary: Provides for one (1) emergency examination per Plan year by the Dentist for the relief of pain.
80%	80%	80%	Oral Surgery: Provides for extractions and other oral surgery including pre and post-operative care.
80%	80%	80%	Regular Restorative: Provides amalgam (silver) restorations; composite (white) resin restorations on all teeth; and stainless steel crowns for dependents under age twelve (12).
50%	50%	50%	MAJOR (Subject to Deductible)
50%	50%	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%	50%	50%	Periodontics: <ol style="list-style-type: none"> Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted toward the frequency limitation for prophylaxis cleanings. Surgical periodontal procedures.
50%	50%	50%	Special Restorative: When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
50%	50%	50%	Prosthodontics: <ol style="list-style-type: none"> Includes bridges, partial and complete dentures. Repairs and adjustments of bridges and dentures.
None	None	None	ORTHODONTICS (Subject to Deductible)
None	None	None	Orthodontics: Orthodontic appliances and treatment.

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.

Summary of Dental Plan Benefits

USD #202 - TURNER

Group #50033-0-1-0

Maximum Benefit(s) Per Person:	Benefit % Paid				
	Delta Dental PPO	Delta Dental Premier	Non-participating		
<p>The Maximum Benefit for all Covered Services for each Enrollee in any one Calendar Year is: One Thousand Two Hundred Dollars (\$1,200.00).</p> <p>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 be included in determining the Maximum Benefit for each Calendar Year.</p>	100%	100%	100%	<p><u>DIAGNOSTIC & PREVENTIVE</u> (Not subject to Deductible)</p> <p>Diagnostic: Includes the following procedures necessary to evaluate existing dental conditions and the dental care required:</p> <ul style="list-style-type: none"> • <u>Oral evaluations</u> – once (1) each six (6) months. • <u>Bitewing x-rays</u> – bitewings once (1) each six (6) months for dependents under age eighteen (18) and once (1) each twelve (12) months for adults age eighteen (18) and over. • <u>Full mouth or panoramic x-rays</u> – once (1) each five (5) years. 	
	100%	100%	100%	<p>Preventive: Provides for the following:</p> <ul style="list-style-type: none"> • <u>Prophylaxis</u> (Cleanings) - once (1) each six (6) months. • <u>Topical Fluoride</u> – once (1) each six (6) months for dependent children under age nineteen (19). • <u>Space Maintainers</u> – for dependent children under age fourteen (14) and only for premature loss of primary molars. • <u>Sealants</u> – once (1) per tooth per lifetime 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. 	
<p>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:</p> <p style="text-align: center;">\$50 x 3</p>	80%	80%	80%	<p><u>BASIC</u> (Subject to Deductible)</p> <p>Ancillary: Provides for one (1) emergency examination per Plan year by the Dentist for the relief of pain.</p>	
	80%	80%	80%	<p>Oral Surgery: Provides for extractions and other oral surgery including pre and post-operative care.</p>	
<p>Eligible Children Ages: Children are eligible for coverage to age nineteen (19) or to age twenty-four (24) if a full-time student.</p>	80%	80%	80%	<p>Regular Restorative: Provides amalgam (silver) restorations; composite (white) resin restorations on all teeth; and stainless steel crowns for dependents under age twelve (12).</p>	
	80%	80%	80%	<p>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.</p>	
	80%	80%	80%	<p>Periodontics:</p> <ol style="list-style-type: none"> Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted toward the frequency limitation for prophylaxis cleanings. Surgical periodontal procedures. 	
	50%	50%	50%	<p><u>MAJOR</u> (Subject to Deductible)</p> <p>Special Restorative: When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.</p>	
	50%	50%	50%	<p>Prosthodontics:</p> <ol style="list-style-type: none"> Includes bridges, partial and complete dentures. Repairs and adjustments of bridges and dentures. 	
	50%	50%	50%	<p><u>ORTHODONTICS</u> (Subject to Deductible)</p> <p>Orthodontics: Includes orthodontic appliances and treatment, interceptive and corrective, for dependent children under age nineteen (19).</p>	

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.