DELTA DENTAL®

EHB Certified Low Plan

Pediatric Essential Health Benefits (EHB) included in plan

For individuals age 18 and under

Delta Dental PPO (Standard)	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
Palliative treatment—to temporarily relieve pain	100%	80%	80%	None
Radiographs—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	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—prosthetic appliances	50%	50%	50%	None
Other basic services—miscellaneous services	50%	50%	50%	None
MAJOR SERVICES				
Prosthodontic services—bridges, dentures and crowns over implants	50%	50%	50%	None
Major restorative services—crowns	50%	50%	50%	None
ORTHODONTIC SERVICES				
Orthodontic services—medically necessary	50%	50%	50%	None

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 $425 per benefit year if this policy covers one eligible person age 18 and under, or $850 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; or (iii) out-of-network dentists. 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 deductible of $150 per family per benefit year. The deductible does not apply to exams, cleanings, fluoride, space maintainers, palliative treatment, sealants and orthodontics.

Annual and lifetime maximum for EHB covered services

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

Payment for orthodontic services (when medically necessary)

When orthodontic treatment begins, your dentist will submit a payment to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your participating dentist equal to 30 percent of Delta Dental's copayment of the maximum approved fee for orthodontic services. Delta Dental will make additional payments as follows: Delta Dental will pay 50 percent of the per-month fee charged by your dentist based on the agreed upon payment plan provided by your dentist to Delta Dental.

Waiting period for EHB covered services

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

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.