



Delta Dental PPO plus Premier Summary of Dental Plan Benefits For Group# 1295-0001, 0099 Brunswick County Schools

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's Maximum Approved Fee for each service and it may vary due to the Dentist's network participation.*

Control Plan - Delta Dental of North Carolina

Benefit Year - September 1 through August 31

Covered Services -

	Minimum*	Maximum*	Increase
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	80%	90%	100%
Emergency Palliative Treatment - to temporarily relieve pain	80%	90%	100%
Sealants - to prevent decay of permanent teeth	80%	90%	100%
Brush Biopsy - to detect oral cancer	80%	90%	100%
Radiographs - X-rays	80%	90%	100%
Basic Services			
Minor Restorative Services - fillings and crown repair	80%	90%	100%
Periodontic Services - to treat gum disease	80%	90%	100%
Other Basic Services - misc. services	80%	90%	100%
Relines and Repairs - to bridges, implants, and dentures	80%	90%	100%
Simple Extractions - extractions of erupted teeth	80%	90%	100%
Major Services			
Endodontic Services - root canals	50%	50%	50%
Major Restorative Services - crowns	50%	50%	50%
Prosthetic Services - bridges, implants, dentures, and crowns over implants	50%	50%	50%
Oral Surgery - surgical extractions and dental surgery	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	0%	0%
Orthodontic Age Limit -	No Age Limit	No Age Limit	

* When you receive services from a 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 Nonparticipating Dentist Fee may be less than what your dentist charges, which means that you will be responsible for the difference.

** 80% coinsurance level applies during the First Plan Year the Member is covered. If the Covered Person visits a dentist during the Plan Year, 90% coinsurance and 100% level of reimbursement will apply during the second and third Plan Year, respectively. If, during any Plan Year, the Covered Person fails to visit a dentist, the 80% level will automatically reapply during the following Plan Year, and the Covered Person must advance as if the Covered Person is a new enrollee.

The explanation and sample calculation of how these services will be paid can be found in Section VI - How Payment is Made in your Certificate.

- Oral exams (including evaluations by a specialist) are payable twice per benefit year.
- Two prophylaxes (cleanings) and/or up to four periodontal maintenance are payable per benefit year, not to exceed a total of four procedures in any benefit year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable once per benefit year for people age 18 and under.
- Space maintainers are payable once per area per lifetime for people age 18 and under.

- Bitewing X-rays are payable twice per Benefit Year for people age 18 and under and once per benefit year for people age 19 and older. Full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are payable once per tooth per lifetime for first and second permanent molars and bicuspid for people age 12 and under. The surface must be free from decay and restorations.
- Crowns, inlays, onlays, gold foil restorations, and substructures are payable once per tooth in any ten-year period.
- Composite resin (white) restorations are payable on posterior teeth.
- Inlays (any material) are payable.
- Gold foils are payable.
- Porcelain and resin facings on crowns are payable on posterior teeth.
- Pulp caps are a Covered Service.
- Vestibuloplasty is a Covered Service.
- Full and partial dentures are payable once in any 10-year period.
- Bridges are payable once in any 10-year period. Precision attachments are payable.
- Implants are payable once per tooth in any 10-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any 10-year period. Services related to crowns over implants are Covered Services.
- Occlusal guards are not Covered Services. Antibiotic drug injections are Covered Services.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – \$1,250 per person total per Benefit Year on all services, except cephalometric films, photos, diagnostic casts and orthodontic services. \$1,000 per person total per lifetime on cephalometric films, photos, diagnostic casts, and orthodontic services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan 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 Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by your Dentist to Delta Dental.

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, emergency palliative treatment, brush biopsy, X-rays, sealants, minor restorative, periodontics, relines and repairs, simple extractions, other basic services, pulp capping, and orthodontic services.

Waiting Period – Enrollees who are eligible for Benefits are covered on the first of the month following the date of hire.

Eligible People – All full-time employees who work at least 30 hours per week, and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees, if applicable. The Subscriber pays the full cost of this plan.

Also eligible are your Spouse and your Children to the end of the month in which they turn 26, including your Children who are married, who no longer live with you, who are not your Dependents for Federal income tax purposes, and/or who are not permanently disabled.

Enrollees and dependents choosing this dental plan are required to remain enrolled for a minimum of 12 months. Should an Enrollee or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Enrollee is enrolled (except under COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate Benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Enrollees under This Plan.

Benefits will cease on the last day of the month following termination.

This plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. This plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

This plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats)

This plan provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, call 1-800-662-8856 (TTY users call 711).

If you believe that this plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with the civil rights coordinator at PO Box 9089, Farmington Hills, MI 48333-9089; by phone at 1-800-662-8856 (TTY users call 711) or fax to 517-706-3513. You can file a grievance by mail, fax or phone. If you need help filing a grievance, the civil rights coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201; 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجاناً بالنسبة لك. اتصل على الهاتف رقم 1-800-662-8856 (رقم الطابعة الهاتفية: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-662-8856 (TTY : 711)。

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-662-8856 (ATS: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-662-8856 (TTY: 711).

ध्यान आपो: જો તમે [ગુજરાતી] બોલતાં હો તો વિના મૂલ્ય ભાષાકીય સહાયતા સેવાઓ તમારે માટે ઉપલબ્ધ છે. કોલ કરો 1-800-662-8856 (TTY: 711).

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। कॉल करें 1-800-662-8856 (TTY: 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-662-8856 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-800-662-8856 (TTY : 711) まで、お電話にてご連絡ください。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-662-8856 (TTY: 711) 번으로 전화해 주십시오.

ໂປດ ຊາບ: ຖ້າວ່າ ທ່ານ ເວົ້າ ພາສາ ລາວ, ການ ບໍລິ ການ ຊ່ວຍ ເຫຼືອ ດ້ານ ພາສາ, ໂດຍບໍ່ ຈ່າຍ ຄ່າ, ແມ່ນມີ
ພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-662-8856 (TTY: 711).

សេចក្តីជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ, មានសេវាកម្មជំនួយផ្នែកភាសាសម្រាប់អ្នក ដោយ
ឥតគិតថ្លៃ។ សូមទៅទូរស័ព្ទទៅលេខ 1-800-662-8856 (TTY: 711) ។

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-800-662-8856 (телетайп: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al
1-800-662-8856 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika
nang walang bayad. Tumawag sa 1-800-662-8856 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số
1-800-662-8856 (TTY: 711).