



**Delta Dental of Kentucky
Delta Dental PPO (Standard)
Summary of Dental Plan Benefits
BUY-UP PLAN**

Group Name: Bardstown Independent Schools

Group Number: 710020

Benefit Year: January 1 through December 31

Covered Services –

	In-Network Plan Pays	Out-of-Network Plan Pays*
Diagnostic & Preventive		
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	90%
Emergency Palliative Treatment – to temporarily relieve pain	100%	90%
Sealants – to prevent decay of permanent teeth	100%	90%
Brush Biopsy – to detect oral cancer	100%	90%
Radiographs – X-rays	100%	90%
Basic Services		
Minor Restorative Services – fillings and crown repair	100%	75%
Oral Surgery Services – extractions and dental surgery	100%	75%
Other Basic Services – misc. services	100%	75%
Denture Repair – repairs to complete or partial dentures	100%	75%
Relines and Rebase – to dentures	100%	75%
Major Services		
Endodontic Services – root canals	60%	40%
Periodontic Services – to treat gum disease	60%	40%
Major Restorative Services – crowns	60%	40%
Fixed Prosthodontic Repair – to bridges	60%	40%
Implant Repair – implant maintenance, repair, and removal	60%	40%
Adjustments to Dentures – adjustments to complete or partial dentures	60%	40%
Prosthodontic Services – bridges, implants, and dentures	60%	40%
Orthodontic Services		
Orthodontic Services – braces	50%	50%
Orthodontic Age Limit –	Dependent children to the end of the month of age 19	

* When services are received from an Out-of-Network Dentist, the percentages in this column indicate the portion of Delta Dental's PPO Dentist Schedule (or the Out-of-Network Dentist Fee) that will be paid for those services. This amount may be less than what the dentist charges or Delta Dental approves and you are responsible for that difference.

Customer Service Toll-Free Number: (800) 955-2030
www.DeltaDentalKY.com

- 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.
- Fluoride treatments are payable once per calendar year for people up to age 19.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are payable once per tooth per two-year period for the occlusal surface of first and second permanent molars up to age 16. The surface must be free from decay and restorations.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain and resin facings on bridges are Covered Services on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.

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, cephalometric films, photos, diagnostic casts and orthodontic services (including surgical repositioning of teeth).

Maximum Payment – \$1,250 per person total per Benefit Year on all services, except cephalometric films, photos, diagnostic casts and orthodontic services (including surgical repositioning of teeth). \$1,000 per person total per lifetime on cephalometric films, photos, diagnostic casts and orthodontic services (including surgical repositioning of teeth).

Missing Teeth-The initial installation of any prosthodontic service is not a Covered Service to replace missing teeth or teeth that were lost before coverage began.

Dependent Age Limit – Dependents are covered up to age 26.

Eligible People – The subscriber (you) is eligible for dental benefits when your employer or organization notifies Delta Dental.

Also eligible at your option are your legal spouse and your children who meet the age requirements noted above. You and your eligible dependents must enroll for a minimum of 12 months. If coverage is terminated after 12 months, you may not re-enroll prior to the open enrollment that occurs at least 12 months from the date of termination. Your dependents may only enroll if you are enrolled (except under COBRA) and must be enrolled in the same plan as you. Plan changes are only allowed during open enrollment periods, except that 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.

If you and your spouse are both eligible under this Contract, you may be enrolled as both a Subscriber on your own application and as a dependent on your spouse's application. Your dependent children may be enrolled on both applications as well. Delta Dental will coordinate benefits.

Benefits will cease on the last day of the month in which the employee is terminated.

Rates:

Employee Only: \$26.51

Employee + Spouse: \$59.31

Employee + Child(ren): \$72.93

Employee + Family: \$103.09