



**Delta Dental PPO (Point-of-Service)  
Summary of Dental Plan Benefits  
For Group# 5630-8010, 8019  
Riverside Local 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 allowance for each service and it may vary due to the dentist's network participation.\*

**Control Plan** – Delta Dental of Ohio

**Benefit Year** – January 1 through December 31

**Covered Services** –

	Delta Dental PPO Dentist Plan Pays	Delta Dental Premier Dentist Plan Pays	Nonparticipating Dentist Plan Pays*
<b>Diagnostic &amp; Preventive</b>			
<b>Diagnostic and Preventive Services</b> – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
<b>Emergency Palliative Treatment</b> – to temporarily relieve pain	100%	100%	100%
<b>Sealants</b> – to prevent decay of permanent teeth	100%	100%	100%
<b>Brush Biopsy</b> – to detect oral cancer	100%	100%	100%
<b>Radiographs</b> – X-rays	100%	100%	100%
<b>Basic Services</b>			
<b>Minor Restorative Services</b> – fillings and crown repair	80%	80%	80%
<b>Endodontic Services</b> – root canals	80%	80%	80%
<b>Periodontic Services</b> – to treat gum disease	80%	80%	80%
<b>Oral Surgery Services</b> – extractions and dental surgery	80%	80%	80%
<b>Other Basic Services</b> – misc. services	80%	80%	80%
<b>Relines and Repairs</b> – to bridges, implants, and dentures	80%	80%	80%
<b>Major Services</b>			
<b>Major Restorative Services</b> – crowns	50%	50%	50%
<b>Prosthodontic Services</b> – bridges, implants, and dentures	50%	50%	50%
<b>Orthodontic Services</b>			
<b>Orthodontic Services</b> – braces	60%	60%	60%
<b>Orthodontic Age Limit</b> –	Up to age 19	Up to age 19	Up to age 19

\* 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. The Nonparticipating Dentist Fee may be less than what the dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar 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 twice 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 lifetime for the occlusal surface of first permanent molars up to age nine and second permanent molars up to age 14. The surface must be free from decay and restorations.

- Composite resin (white) restorations are Covered Services on posterior teeth.
- Metallic inlays are Covered Services.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.

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** – \$1,200 per person total per Benefit Year on all services except orthodontic services. \$1,000 per person total per lifetime on orthodontic services.

**Deductible** – \$50 Deductible per person total per Benefit Year limited to a maximum Deductible of \$100 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants, and orthodontic services.

Any expenses incurred by an eligible person for covered services during the last three months of a benefit year and applied to the Deductible for that benefit year will also be applied to the Deductible for the following Benefit Year.

**Waiting Period** – Employees who are eligible for dental benefits are covered first of the month following date of hire.

**Eligible People** – All regularly scheduled to work employees of the Contractor, subject to the board contract and grandfathered families to age 26 who choose the dental plan (8010) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees (8019). The cost of this plan will be determined by the board approved contract.

Also eligible are your legal 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.

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 to enroll in This Plan as Subscribers, 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 Subscribers under This Plan.

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

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 1-800-524-0149 (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 1-800-524-0149 (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>.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-524-0149 (TTY: 711).

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل على الهاتف رقم 1-800-524-0149 (رقم الطابعة الهاتفية: 711).

মনোযোগ দিন: আপনি যদি বাংলা ভাষায় কথা বলেন, তাহলে ভাষাগত সহায়তা পরিসেবাগুলি, আপনার জন্য বিনামূল্যে পাওয়া যাবে। ফোন করুন 1-800-524-0149 (TTY: 711)।

သတိပြုရန်- သင် မြန်မာဘာသာစကား ပြောဆိုပါကဘာသာစကားအကူအညီဝန်ဆောင်မှုများကိုအခမဲ့ရရှိနိုင်ပါသည်။ ခေါ်ဆိုရန် 1-800-524-0149 (TTY- 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 1-800-524-0149 (TTY：711)。

XIYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-524-0149 (TTY: 711).

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-524-0149 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-524-0149 (ATS: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-524-0149 (TTY: 711).

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए निःशुल्क उपलब्ध हैं। कॉल करें 1-800-524-0149 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-524-0149 (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。1-800-524-0149 (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. 1-800-524-0149 (TTY: 711) 번으로 전화해 주십시오.

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਇੱਥੇ ਕਾਲ ਕਰੋ 1-800-524-0149 (TTY: 711).

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kannsch du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-524-0149 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-524-0149 (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-524-0149 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-524-0149 (телетайп: 711).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-524-0149 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-524-0149 (TTY: 711).

يرجى الانتباه: إذا كنت تتحدث اللغة العربية السورية، تتوفر لك خدمات المساعدة اللغوية المجانية. يرجى الاتصال بالرقم: 1-800-524-0149 (الهاتف النصي: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-524-0149 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-524-0149 (телетайп: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-524-0149 (TTY: 711).