

HIGHLIGHTS	AMOUNTS COVERED
CALENDAR YEAR DEDUCTIBLE	
Per benefit period	\$50 per person \$150 per family maximum
CALENDAR YEAR PROGRAM MAXIMUM	
When the calendar year program maximum is reached, the Subscriber pays 100% until the end of the benefit period	\$1,000 per person
DIAGNOSTIC AND PREVENTIVE (deductible waived)	
Routine Exams (oral exams limited to once every six months)	100%*
X-rays <ul style="list-style-type: none"> • Periapical X-rays as required • Bitewing X-rays once in six months • Full mouth X-rays once in three years 	100%*
Fluoride Treatments (once in any period of six consecutive months for dependent children to age 19)	100%*
Prophylaxis (once every six months)	100%*
Sealants (for dependent children to age 15 on permanent first molars and permanent second molars; one sealant per tooth in any period of 36 consecutive months)	100%*
Space Maintainers (for dependent children to age 19)	100%*
Palliative Emergency Treatment (acute condition requiring immediate care)	100%*
Consultations	100%*
BASIC SERVICES	
Basic Restorative (amalgam "silver" fillings and composite "white" non-molar fillings)	80%*
Endodontics (procedures for pulpal therapy and root canal filling)	80%*
Periodontics (treatment to the gums and supporting structures of the teeth; surgical and non-surgical periodontal treatment is covered)	80%*
Oral Surgery (extraction and oral surgery procedures, including pre- and post-operative care; general anesthesia is covered when used in conjunction with covered oral surgical procedures)	80%*
MAJOR SERVICES	
Major Restorative (crowns, inlays, onlays)	50%*
Prosthodontics (procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures; prosthetic replacement limited to once in five years)	50%*
ORTHODONTICS	
Orthodontic Treatment (covered for dependent children to age 19; procedure for straightening teeth)	50%*
ORTHODONTICS LIFETIME MAXIMUM	
Lifetime maximum per dependent	\$1,000

*Percentage is based on the DeltaPremier Maximum Plan Allowance (MPA) or the dentist's fee, whichever is less (the Allowed Amount). The Delta payment under the program, plus the patient payment, equals the Allowed Amount, which is accepted by Delta participating dentists (*Pennsylvania and Maryland only*) as full payment. Participating dentists are paid directly by Delta, and by agreement cannot bill you more than the applicable copayment, deductible or charges where maximums have been exceeded for covered services. By selecting a participating dentist, you always limit your out-of-pocket costs.

For services performed by non-participating dentists, Delta sends the benefit payment directly to you. You are responsible for paying the non-participating dentist's total fee, which may include amounts in addition to your share of Delta's Allowed Amount, such as applicable copayments, deductibles and charges where maximums have been exceeded and services not covered by the Group Dental Service Contract.

Programs are subject to change. This is a general description of benefits, limitations and exclusions of the dental plan coverage; the terms and conditions of coverage shall be governed solely by the contract issued to the group. Contact your employer or marketing representative for additional benefit details.

Deductibles, coinsurance and copayments under this program are separate from any deductibles, coinsurance and copayments described in your company's other health benefits coverage.

Dependents are eligible for covered services to age 19 unless they are students in a bona fide institute of higher education in which case, eligibility is extended to age 23. Major Services – There is a six-month waiting period on major services for groups under 50 lives with no prior coverage.

Capital BlueCross has arranged for dental benefits to be issued and administered by Delta Dental of Pennsylvania.

Capital BlueCross is an Independent Licensee of the Blue Cross and Blue Shield Association
Delta Dental of Pennsylvania is a member of the nationwide Delta Dental Plans Association

Delta Dental – Standard Benefit Exclusions

The group contract will contain standard benefit exclusions and limitations (which will vary by contract and riders purchased).

EXCLUSIONS

Except as specifically provided in the Contract and in addition to any limitations set forth in the Contract, no benefits shall be provided for:

1. Services or supplies which are provided to patient by any federal or state government agency except Medicaid, or by any municipality, county, or other political subdivision;
2. Charges for which benefits or services are provided to the patient by any hospital, medical or dental service corporation, any group insurance, franchise, or other prepayment plan for which an employer, union, trust or association makes contributions or payroll deductions (unless the coordination of benefit provisions provide otherwise);
3. Treatment or supplies with respect to congenital malformations;
4. Treatment or devices that increase the vertical dimension of an occlusion, restore an occlusion to normal, replace tooth structure lost by attrition or erosion, or otherwise;
5. Treatment or supplies primarily for cosmetic purposes;
6. Services provided or supplies furnished or devices started prior to the effective eligibility date of a patient;
7. Preventive plaque control programs, including oral hygiene programs;
8. Fissure sealants unless covered under the group contract;
9. Periodontal splinting, equilibration and gnathological recordings;
10. Myofunctional therapy;
11. Temporomandibular joint dysfunction, unless covered under the group contract;
12. Implants;
13. Prescription drugs, pre-medication, analgesias, and general anesthesia, unless covered under the group contract;
14. Treatment or supplies for which the patient would have no legal obligation to pay in the absence of this or any other similar coverage; and
15. Experimental procedures which have not been accepted by the American Dental Association.