DELTA DENTAL®

Renaissance®

Underwritten by Renaissance Life & Health Insurance Company of America

EHB Certified High Plan

Pediatric Essential Health Benefits (EHB) included in plan

For individuals under the age of 19

MAXIMUMS AND DEDUCTIBLE	
Deductible (per benefit year) **Deductible waived for these services*	$50 per member/$150 per family
Annual out-of-pocket maximum for EHB covered services	$350 per individual under age 19; $700 for two or more individuals under age 19

Delta Dental PPO	IN NETWORK		OUT OF NETWORK	WAITING PERIODS
	Delta Dental PPO℠ dentist	Delta Dental Premier® dentist	Nonparticipating dentist	
	You pay	You pay	You pay	
DIAGNOSTIC AND PREVENTIVE SERVICES				
Diagnostic and preventive services*—exams, cleanings, fluoride and space maintainers	No charge	No charge	No charge	None
Brush biopsy*—to detect oral cancer	No charge	No charge	No charge	None
Emergency palliative treatment*—to temporarily relieve pain	No charge	No charge	No charge	None
Radiographs*—X-rays	No charge	No charge	No charge	None
Sealants*—to prevent decay of permanent teeth	No charge	No charge	No charge	None
BASIC SERVICES				
Minor restorative services—fillings and crown repair	20%	30%	30%	None
Oral surgery services—extractions and dental surgery and services for the diagnosis and treatment of temporomandibular disorders including craniomandibular and temporomandibular joint disorders (coverage for craniomandibular and temporomandibular joint disorders includes both surgical and nonsurgical procedures)	20%	30%	30%	None
Endodontic services—root canals	20%	30%	30%	None
Periodontic services—to treat gum disease	20%	30%	30%	None
Relines and repairs—to bridges and dentures	20%	30%	30%	None
Other basic services—miscellaneous services	20%	30%	30%	None
MAJOR SERVICES				
Prosthodontic services—bridges, implants and dentures	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 under the age of 19 that are considered Essential Health Benefits as defined by the Patient Protection and Affordable Care Act.

In-network out-of-pocket maximum EHB covered services

An out-of-pocket maximum is the maximum amount that you or an eligible dependent will pay for covered services throughout a benefit year. The in-network annual out-of-pocket maximum for EHB covered services shall be $350 per benefit year if this policy covers one individual, or $700 per benefit year if this policy covers two or more individuals. Any coinsurance, copayments, deductibles or other out-of-pocket expenses paid by you for in-network EHB covered services shall count toward that in-network out-of-pocket maximum. The in-network out-of-pocket maximum will not include any amounts paid for the following: (i) premiums; (ii) non-covered services; (iii) out-of-network dentists. Once your applicable in-network out-of-pocket maximum is reached for the benefit year, all in-network EHB covered services provided to individuals under the age of 19 will be covered at 100 percent of the maximum approved fee.

In-network out-of-pocket maximum EHB covered services

There is no annual out-of-pocket maximum for out-of-network EHB covered services. You will be responsible for all coinsurance, copayments, deductibles and balance billing amounts associated with all out-of-network EHB covered services provided to you or your eligible dependent throughout the benefit year.

Deductible for EHB covered services

$50 per individual per benefit year, limited to a maximum of $150 per family per benefit year. The deductible does not apply to diagnostic and preventive services, brush biopsy, emergency palliative treatment, X-rays, 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 plan.

Waiting period for EHB covered services

There are no waiting periods for individuals under the age of 19 seeking EHB covered services.

Limitations

- Oral exams are payable once every six months.
- Bitewing images are payable once every 12 months, and panoramic or full-mouth images (which include bitewing images) are payable once in any 60-month period whether provided by a general dentist or specialist.
- Routine prophylaxes (cleanings) are payable once every six months.
- Topical fluoride treatments are payable once every six months.
- Sealants are only payable on permanent molars and only once per tooth every 60 months.
- Composite resin (white) restorations are covered services on all teeth.
- Pre-fabricated resin based composite crowns or stainless steel crowns are payable once per tooth every 60 months and only when medically necessary.
- Pulpotomies are payable for primary teeth and only when a periapical lesion is present.
- Root canals are a covered services only when medically necessary.
- Periodontal scaling and root planing is payable once per 24 months and only when medically necessary.
- Gingivectomies or gingivoplasties, osseous surgeries, bone grafts, and guided tissue regeneration treatments are payable once every 36 months and only when medically necessary.
- Complete and partial maxillary and mandibular dentures are payable once every 60 months and only when medically necessary.
- Adjustments, repairs and relines of dentures are payable once every 60 months and only when medically necessary.
- Maxillary and mandible overdentures are payable once every 60 months and only when medically necessary.
- Alveoloplasty is payable once per lifetime.
- Medically necessary orthodontia is payable once per lifetime.
- Medically necessary TMD is a covered service.
- Sedation and nitrous oxide are covered services when seeking emergency care.

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.

Administered by Delta Dental Plan of Michigan, Inc. and underwritten by Renaissance Life & Health Insurance Company of America, PO Box 1596, Indianapolis, IN 46206

DELTA DENTAL®

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EHB Certified High Plan

Non-EHB covered services included in plan

For individuals 19 years of age or older, or individuals under the age of 19 seeking non-EHB covered services

MAXIMUMS AND DEDUCTIBLE	
Deductible (per benefit year) **Deductible waived for these services*	$50 per member/$150 per family
Benefit year maximum	$1,000 per member

Delta Dental PPO	IN NETWORK		OUT OF NETWORK	WAITING PERIODS
	Delta Dental PPO℠ dentist	Delta Dental Premier® dentist	Nonparticipating dentist	
	You pay	You pay	You pay	
DIAGNOSTIC AND PREVENTIVE SERVICES				
Diagnostic and preventive services*—exams, cleanings, fluoride and space maintainers	No charge	No charge	No charge	None
Brush biopsy*—to detect oral cancer	No charge	No charge	No charge	None
Emergency palliative treatment*—to temporarily relieve pain	No charge	No charge	No charge	None
Radiographs*—X-rays	No charge	No charge	No charge	None
Sealants—to prevent decay of permanent teeth	No charge	No charge	No charge	None
BASIC SERVICES				
Minor restorative services—fillings and crown repair	20%	30%	30%	6 months
Oral surgery services—extractions and dental surgery and services for the diagnosis and treatment of temporomandibular disorders including craniomandibular and temporomandibular joint disorders (coverage for craniomandibular and temporomandibular joint disorders includes both surgical and non-surgical procedures)	20%	30%	30%	6 months
Endodontic services—root canals	20%	30%	30%	6 months
Periodontic services—to treat gum disease	20%	30%	30%	6 months
Relines and repairs—to bridges and dentures	20%	30%	30%	6 months
Other basic services—miscellaneous services	20%	30%	30%	6 months
MAJOR SERVICES				
Prosthodontic services—bridges, implants and dentures	50%	50%	50%	12 months
Major restorative services—crowns	50%	50%	50%	12 months

Stay in network and save!

You can go to any licensed dentist, but you generally will save money if you go to a dentist who participates in one of our two networks—Delta Dental PPO or Delta Dental Premier. That's because Delta Dental has established maximum approved fees for nearly all dental services, and participating dentists agree to accept the maximum approved fee as full payment for those services. If the dentist's fee is higher than Delta Dental's, he or she cannot charge you the difference. This means you are responsible only for your copayments and deductibles, if any, when you visit a Delta Dental participating dentist.

What if I go to a nonparticipating dentist?

If you go to a dentist who does not participate in Delta Dental PPO or Delta Dental Premier, you will still be covered, but you may have to pay more. The percentages shown above indicate the portion of Delta Dental's nonparticipating dentist fee that will be paid for those services. This amount may be less than what the dentist charges and you are responsible for the difference. We will pay you directly and you will be responsible for paying the dentist whatever he or she charges. You may also have to submit your own claims.

Non-EHB covered services

Non-EHB covered services include all covered services that are not Essential Health Benefits as defined by the Patient Protection and Affordable Care Act.

Maximum payment for non-EHB covered services

$1,000 per individual per benefit year on all services.

Out-of-pocket maximum payment for non-EHB covered services

An out-of-pocket maximum is the maximum amount that you or your eligible dependent will pay for covered services throughout a benefit year. There is no annual out-of-pocket maximum payment for non-EHB covered services. You will be responsible for all coinsurance, copayments, deductibles and balance billing amounts associated with all non-EHB covered services provided to you or your eligible dependent throughout the benefit year.

Deductible for non-EHB covered services

For individuals 19 years of age or older, or individuals under the age of 19 seeking non-EHB covered services, the deductible per individual per benefit year is $50, limited to a maximum of $150 per family per benefit year. The deductible does not apply to diagnostic and preventive services, brush biopsy, emergency palliative treatment and X-rays.

Waiting period for non-EHB covered services

Individuals will be eligible for coverage for diagnostic and preventive, basic, and major services in accordance with the applicable waiting periods set forth in the covered services chart above, measured from your or their date of coverage under this policy.

Eligible dependents enrolled after your date of enrollment will have their own waiting periods in accordance with the above.

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.

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