

Dental Plan Coverage Summary - 2010

Overview of benefits. Please check the "Evidence of Coverage" for detailed coverage information and exclusions.

	<u>In-Network Care</u> <i>Applies when treated by an in-network - participating - dental care provider (a provider who participates in a Delta Dental network).</i>	<u>Out-of-Network Care</u> <i>Applies when treating with an out-of-network - non-participating - dental care provider.</i>
Annual Benefit Maximum (maximum coverage provided on behalf of a covered individual)	\$1,000 per person / calendar year (maximum total reimbursement for both in-network and out-of-network treatment)	\$1,000 per person / calendar year (maximum total reimbursement for both in-network and out-of-network treatment)
Claim Forms	Not required	Member must submit a claim form to Delta Dental if treatment is received from an out-of-network (non-participating) dental care provider.
Coinsurance (dental plan's payment / member's payment, after deductibles are paid)	Diagnostic and Preventive Care: 100% / 0% Basic Restorative Services: 80% / 20% Major Restorative Services: 50% / 50%	Diagnostic and Preventive Care: 100% of Delta Dental's normal provider reimbursement rates Basic Restorative Services: 80% Major Restorative Services: 50% The participant pays all fees charged by their non-participating provider in excess of Delta Dental's contracted provider reimbursement rates.
Deductible (per calendar year; does not apply to routine cleanings & exams, sealants, and orthodontics)	\$50 per individual, up to \$150 per family (If deductible is not met until Oct., Nov., or Dec., no deductible has to be met the following calendar year.)	\$50 per individual, up to \$150 per family (If deductible is not met until Oct., Nov., or Dec., no deductible has to be met the following calendar year.)
Emergency Care	Covered at applicable coinsurance rate.	Coverage is provided at the "in-network" level in the event the participant cannot be treated by a participating dentist.
Customer Service Toll-free Number	Delta Dental: (800) 932-0783	Delta Dental: (800) 932-0783
Office Visit Co-Payments	N/A (coinsurance applies)	N/A (coinsurance applies)
Orthodontia Services	50% coverage is provided for orthodontia services for children through age 18, up to a maximum lifetime benefit of \$1,000 per child	50% coverage is provided for orthodontia services for children through age 18, up to a maximum lifetime benefit of \$1,000 per child. The participant pays all fees charged by their non-participating provider in excess of Delta Dental's contracted provider reimbursement rates.
Participant-paid Monthly Premiums	\$25.44 / month - single coverage \$44.49 / month - plus 1 dependent \$66.48 / month - family coverage	
Participating Providers	Delta maintains two provider networks - the Delta Dental PPO and the Delta Dental Premier network. Participants generally will experience the lowest out-of-pocket costs when visiting a dentist who participates in the Delta Dental PPO network. To locate a participating Delta Dental provider, visit www.MidAtlanticDeltaDental.com or call (800) 932-0783.	
Routine Exams / Cleanings	Coverage is provided for up to 2 routine exams and cleanings per calendar year, per person.	Coverage is provided for up to 2 routine exams and cleanings per calendar year, per person.