



EHB Certified High Plan

Pediatric Essential Health Benefits (EHB) included in plan

For individuals age 18 and under

| Delta Dental PPO (Point-of-Service) | IN NETWORK | | OUT OF NETWORK | WAITING PERIODS |
|---|---------------------------|-------------------------------|--------------------------|-----------------|
| | Delta Dental PPO™ dentist | Delta Dental Premier® dentist | Nonparticipating dentist | |
| | Plan pays | Plan pays | Plan pays | |
| DIAGNOSTIC AND PREVENTIVE SERVICES | | | | |
| Diagnostic and preventive services—exams, cleanings, fluoride and space maintainers | 100% | 100% | 100% | None |
| Brush biopsy—to detect oral cancer | 100% | 100% | 100% | None |
| Palliative treatment—to temporarily relieve pain | 100% | 100% | 100% | None |
| Radiographs—X-rays | 100% | 100% | 100% | None |
| Sealants—to prevent decay of permanent teeth | 100% | 100% | 100% | None |
| BASIC SERVICES | | | | |
| Minor restorative services—fillings and crown repair | 80% | 60% | 60% | None |
| Oral surgery services—extractions and dental surgery | 80% | 60% | 60% | None |
| Endodontic services—root canals | 80% | 60% | 60% | None |
| Periodontic services—to treat gum disease | 80% | 60% | 60% | None |
| Relines and repairs—prosthetic appliances | 80% | 60% | 60% | None |
| Other basic services—miscellaneous services | 80% | 60% | 60% | None |
| MAJOR SERVICES | | | | |
| Prosthodontic services—bridges, dentures and crowns over implants | 50% | 50% | 50% | None |
| Major restorative services—crowns | 50% | 50% | 50% | None |



EHB covered services

EHB covered services include covered services to individuals age 18 and under that are considered Essential Health Benefits as defined by the Patient Protection and Affordable Care Act.

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

An annual out-of-pocket maximum is the maximum amount that you or a covered person will pay for EHB covered services throughout a benefit year. The in-network annual out-of-pocket maximum for EHB covered services shall be \$450 per benefit year if this policy covers one covered person, or \$900 per benefit year if this policy covers two or more covered persons. Any coinsurance, copayments, deductibles or other out-of-pocket expenses paid by a covered person for in-network EHB covered services shall count toward that in-network annual out-of-pocket maximum. The in-network annual out-of-pocket maximum will not include any amounts paid for the following: (i) premiums; (ii) non-covered services; or (iii) out-of-network dentists. Once the applicable in-network annual out-of-pocket maximum is reached for the benefit year, all in-network EHB covered services provided to covered persons will be covered at 100 percent of the maximum approved fee.

Out-of-network out-of-pocket maximum for EHB covered services

There is no annual out-of-pocket maximum for out-of-network EHB covered services. Covered persons will be responsible for all coinsurance, copayments, deductibles and other out-of-pocket expenses associated with all out-of-network EHB covered services provided to covered persons throughout the benefit year.

Deductible for EHB covered services

None.

Annual and lifetime maximum for EHB covered services

There are no annual or lifetime maximum payments for EHB covered services under this policy.

Waiting period for EHB covered services

There are no waiting periods for covered persons age 18 and under seeking EHB covered services.

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 bicupid); 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.