

**DELTA DENTAL PPO PLUS PREMIER™ – SELECT PLUS PLAN
SUMMARY OF BENEFITS
FOR COVERED EMPLOYEES OF:**

Supplemental Select Plus Plan

(See Dental Benefit Handbook for definitions of capitalized terms.)

**GROUP NUMBER: 50319 – 00000
50419 – 00000**

EFFECTIVE DATE OF PROGRAM: January 1, 2019

OPEN ENROLLMENT

Changes in enrollment status will be considered during an Open Enrollment Period prior to the Contract renewal date, with changes becoming effective on the renewal date.

WAITING PERIOD

Employees and their Dependents who apply for coverage after their initial eligibility period or without a qualifying event (loss of spousal benefits, marriage, divorce, birth or adoption, or the loss of employee coverage through another insurer) will:

Wait until the next Open Enrollment Period.

TERMS OF ELIGIBILITY

Eligibility begins:

For eligible new employees, eligibility begins the first day of the month following the waiting period.

For eligible new employees, the waiting period is 0 days.

For employees enrolling their Dependents:

Dependent children are eligible through the end of the month in which they attain age 26, regardless of student status, or if age 26 and beyond, to the date they lose eligibility due to the Dependent's inability to meet all of the requirements in the Handbook.

Employees must work for a state agency and qualify for eligibility under Wis. Stats. §40.51.

DEDUCTIBLE LIMITATIONS

Delta Dental shall not be obligated to pay any Deductible specified below.

The Deductible for Dental Procedures provided by Delta Dental PPOSM Providers is \$25 per Subscriber and per Covered Dependent, per Benefit Accumulation Period.

The Deductible for Dental Procedures provided by Delta Dental Premier[®] Providers is \$25 per Subscriber and per Covered Dependent, per Benefit Accumulation Period.

MAXIMUM BENEFIT

The maximum total Benefit payable in any Benefit Accumulation Period is limited to the amount specified below.

The maximum total Benefit per Subscriber and per Covered Dependent, per Benefit Accumulation Period for Dental Procedures provided by Delta Dental PPO Providers is \$2,500, or \$2,500 for Dental Procedures provided by Delta Dental Premier Providers. In no case will the maximum total Benefit exceed \$2,500 regardless of the network chosen.

ORTHODONTIC MAXIMUM BENEFIT

Delta Dental's obligation for orthodontic Benefits is limited to the lifetime maximum specified below.

The maximum lifetime orthodontic Benefit is \$1,500 for Dental Procedures provided by Delta Dental PPO Providers for each Subscriber and each Covered Dependent. Dependent children are covered to age 26.

The maximum lifetime orthodontic Benefit is \$1,500 for Dental Procedures provided by Delta Dental Premier Providers for each Subscriber and each Covered Dependent. Dependent children are covered to age 26.

In no case will the maximum lifetime orthodontic Benefit exceed \$1,500 regardless of the network chosen.

SCHEDULE OF BENEFITS, LIMITATIONS AND COVERAGE PERCENTAGE:

This Contract provides the following Benefits subject to the Coverage percentage listed for each Benefit and subject to any applicable Deductible. The Coverage and Coinsurance percentages may vary based upon the network membership of the treating Provider at the time the Dental Procedure is completed. The application of the Deductible, if any, also may vary based upon the network membership of the treating Provider at the time the Dental Procedure is completed.

For example, if the Coverage percentage shown is "80," that Benefit is 80% of the Maximum Plan Allowance, after satisfaction of any applicable Deductible. In the same

example, the Coinsurance (the amount the patient must pay) would be the remaining 20%.

If the Coverage percentage shown is "0", that Benefit is not provided in the Group Contract.

The Benefit Accumulation Period begins on January 1, 2019, ends on December 31, 2019 and thereafter shall be the 12 month period beginning on January 1st.

PPO = Delta Dental PPO Provider Premier = Delta Dental Premier Provider NC = Noncontracted Provider

Does Deductible Apply? Yes/No			Coverage Percentage			Benefit
PPO	Premier	NC	PPO	Premier	NC	
N	N	N	0	0	0	Evaluations at six month intervals.
N	N	N	0	0	0	Full mouth series x-rays at thirty six month intervals; either individual images, or panoramic image, including bitewings.
N	N	N	0	0	0	Bitewing x-rays at six month intervals (limited to a set of four images).
N	N	N	0	0	0	Prophylaxis (teeth cleaning) or periodontal maintenance procedure at six month intervals.
N	N	N	0	0	0	Prophylaxis.
N	N	N	0	0	0	Periodontal maintenance procedure.
N	N	N	0	0	0	Topical fluoride applications at six month intervals for Covered Dependent children up to age 19.
N	N	N	0	0	0	Space maintainers for retaining space when a posterior primary tooth is prematurely lost.
N	N	N	0	0	0	Emergency treatment to relieve pain.
N	N	N	0	0	0	Topical application of sealants for Covered Dependents up to age 14. Application is limited to the occlusal surface of permanent molars which are free of decay and restorations. Benefits for sealants are limited to one application per tooth per lifetime.
N	N	N	0	0	0	Amalgam (silver) restorations.
N	N	N	0	0	0	Composite (tooth colored) restorations for anterior teeth.

Does Deductible Apply? Yes/No			Coverage Percentage			Benefit
PPO	Premier	NC	PPO	Premier	NC	
Y	Y	NA	80	80	0	Prefabricated crowns – one per tooth at three year intervals.
Y	Y	NA	80	80	0	Endodontics including root canal treatment.
Y	Y	NA	80	80	0	Surgical endodontic treatment.
Y	Y	NA	80	80	0	Non-surgical periodontics, including procedures necessary for the treatment of diseases of the gums and bone supporting the teeth. Benefit is limited to once per quadrant at 24 month intervals.
Y	Y	NA	80	80	0	Surgical periodontic treatment; benefit is limited to once per quadrant at 36 month intervals.
N	N	N	0	0	0	Non-surgical extractions.
Y	Y	NA	80	80	0	Oral surgery (cutting procedures) and surgical extractions including pre-operative and post-operative care.
Y	Y	NA	60	60	0	Crowns, inlays, or onlays are provided when teeth are broken down by dental decay or accidental injury and may no longer be restored adequately with a filling material. Coverage for the purpose of replacing a defective existing crown, inlay or onlay will be provided only after a five year period from the date on which the defective item was last supplied, whether or not Delta Dental paid for the original Dental Procedure as a Benefit under this Contract. Porcelain veneers on crowns are Benefits on the six front teeth, bicuspids, and upper first molars.

Does Deductible Apply? Yes/No			Coverage Percentage			Benefit
PPO	Premier	NC	PPO	Premier	NC	
Y	Y	NA	60	60	0	<p>Prosthetics, including fixed bridgework, implants, partial dentures, and complete dentures to replace missing permanent teeth. Coverage for the purpose of replacing a defective existing prosthetic will be provided only after a five year period from the date on which the defective item was last supplied, whether or not Delta Dental paid for the original Dental Procedure as a Benefit under this Contract.</p> <p>Porcelain veneers on crowns or pontics are Benefits on the six front teeth, bicuspid, and upper first molars.</p> <p>Fixed bridges, implants, partial/complete dentures are provided where chewing function is impaired due to missing teeth. A fixed bridge or implant and implant related procedures may be a Benefit if no more than two teeth are missing in the dental arch in which the bridge or implant is proposed. Delta Dental will provide for replacement of missing teeth with the least elaborate procedure when three or more teeth are missing in the dental arch.</p> <p>Coverage for initial replacement of teeth is not limited to those lost while a Subscriber or Covered Dependent.</p>
Y	Y	NA	60	60	0	<p>Repairs and adjustments to prosthetic appliances. Denture relines or rebase is a Benefit at three year intervals.</p>

Does Deductible Apply? Yes/No			Coverage Percentage			Benefit
PPO	Premier	NC	PPO	Premier	NC	
Y	Y	NA	50	50	0	<p>Orthodontic appliances, treatment and related services for orthodontic purposes including evaluation, x-rays, extractions, photographs, and study models, subject to the orthodontic maximum benefit.</p> <p>Repair or replacement of orthodontic appliances are not covered.</p> <p>Delta Dental calculates all orthodontic treatment schedules according to the following formula:</p> <ul style="list-style-type: none"> - 25% of the total Maximum Plan Allowance (subject to the Coverage Percentage stated herein and any applicable Deductible) is considered the initial payment to be paid by Delta Dental, subject to the Coverage Percentage, any applicable Deductible and the orthodontic maximum Benefit stated herein. - The remainder of the Maximum Plan Allowance is divided by the months of treatment and the resulting amount is paid monthly by Delta Dental, subject to the Coverage Percentage, any applicable Deductible and the orthodontic maximum Benefit stated herein. <p>If orthodontic treatment is stopped for any reason before it is complete, Delta Dental will suspend all monthly payments.</p> <p>Coverage includes orthodontic treatment in progress. Treatment is in progress if an appliance or banding has been placed and the patient is receiving treatment by the attending orthodontist according to a current treatment plan. Liability for orthodontic treatment in progress shall extend only to the unearned portion of the treatment in progress (that portion occurring after enrollment) and Delta Dental shall be the sole determinant of this unearned amount eligible for coverage. However, there are no Benefits available for Dental Procedures, including orthodontic treatment in progress, after coverage terminates.</p>

OPTIONAL PROCEDURES

In some instances, more than one Dental Procedure may be effective in repairing a tooth or dental arch to contour or function. Delta Dental will pay the applicable Maximum Plan Allowance for the least expensive Dental Procedure that is adequate to restore the tooth or dental arch. If a Subscriber or Covered Dependent requests a more expensive Dental Procedure to restore function, only the Maximum Plan Allowance for the least expensive procedure will be reimbursed. The more expensive Dental Procedure must be a covered Benefit of this Contract to receive reimbursement. The Subscriber or Covered Dependent will be responsible for either the remainder of the Provider's fee if a more expensive covered Dental Procedure is selected or the entire fee if the more expensive Dental Procedure is not a Benefit. The Coinsurance and Deductible will apply regardless of which Dental Procedure is selected.

SPECIAL CONDITIONS

Changes in Coverage due to a qualifying event will be effective as defined by Group.

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