A Dental Option for Shawnee Mission School District Group # 2604 - PPO Effective: January 1, 2016

As a participant in the Delta Dental PPO program, you MUST choose a PPO network dentist from the Delta Dental PPO directory for all of the dental care needs of you and your family. Benefits are only available with dentists participating in the Delta Dental PPO network.

Dental services which are not performed by a Delta Dental PPO Dentist will not be covered by the program.

Summary of Benefits

- The Delta Dental PPO program covers the following types of care:
- Preventive (exams, x-rays, cleanings, fluoride treatments).
- Basic (extractions, root canals, oral surgery, restorations).
- Major (crowns, dentures, bridges).
- Orthodontics, lifetime maximum $1,000. Payment for Orthodontic Services shall not be included in determining the Maximum Benefit for each Calendar year. Orthodontic benefit for dependent children under age nineteen (19) and adults.
- Annual maximum benefit, $1,000 in any one calendar year. Calendar year means January 1st thru December 31st.
- Dependents are covered to the end of the calendar year in which they turn the age of twenty-six (26).

The program has certain limitations and exclusions. A partial Limitations and Exclusions of Benefits list is included in this document.

ATTENTION!

THIS IS ONLY A BRIEF SUMMARY OF THE PROGRAM. If there are questions regarding the program or coverage, they should be referred to Delta Dental of Kansas.

If you have any questions or need additional information, contact Customer Service at:

Delta Dental of Kansas, Inc.
P.O. Box 789769
Wichita, KS 67278-9769
1-800-234-3375
www.deltadentalks.com

Advantages

NO DEDUCTIBLES
There are no required deductibles to pay, so your benefits begin immediately following your effective date of coverage. Fixed copayments and non-covered benefits are the only expenses.

NO PRE-EXISTING CONDITIONS RESTRICTED
Pre-existing conditions are NOT excluded under this program.

NO WAITING PERIODS
You may receive benefits for services beginning on your first day of coverage. Even major restorative procedures are not subject to waiting periods.

CHOICE OF PPO DENTISTS
Delta Dental of Kansas provides you with an extensive choice of Delta Dental PPO participating dentists. You may choose any Delta Dental PPO dentist. Please refer to the Delta Dental PPO directory or you may visit our website at www.deltadentalks.com.

YOUR OUT-OF-POCKET EXPENSES ARE CLEARLY DEFINED
The "Patient Payment Schedule" identifies your total cost for each procedure. A procedure listed as "No Cost" requires no payment from you.

Attention dentists: This patient payment schedule represents the patient co-payments under this specific plan. Your total reimbursement will be based off the Delta Dental PPO maximum plan allowance. Claims for **all** procedures performed should be filed to Delta Dental of Kansas for payment.

Patient Payment Schedule

DIAGNOSTIC

Codes	Description	Patient Pays
0120	Periodic oral evaluation – established patient	No Cost
0140	Limited oral evaluation – problem focused	No Cost
0145	Oral evaluation for a patient under three (3) years of age and counseling with primary caregiver	No Cost
0150	Comprehensive oral evaluation – new/established patient	No Cost
0160	Detailed and extensive oral evaluation – problem focused, by report	No Cost
0170	Re-evaluation – limited, problem focused (established patient)	No Cost
0171	Re-evaluation – post-operative office visit	No Cost
0180	Comprehensive periodontal evaluation – new or established patient	$45.00
0210	Intraoral – complete series of radiographic images	No Cost
0220	Intraoral – periapical first radiographic image	No Cost
0230	Intraoral – periapical each additional radiographic image	No Cost
0240	Intraoral – occlusal radiographic image	No Cost
0250	Extra-oral – 2D projection radiographic images created using a stationary radiation source	No Cost
0251	Extra-oral – posterior dental radiographic image	No Cost
0270	Bitewing – single (1) radiographic image	No Cost
0272	Bitewings – two (2) radiographic images	No Cost
0273	Bitewings – three (3) radiographic images	No Cost
0274	Bitewings – four (4) radiographic images	No Cost
0277	Vertical bitewings – seven (7) to eight (8) radiographic images	No Cost
0330	Panoramic radiographic image	No Cost
0460	Pulp vitality tests	No Cost
0470	Diagnostic casts	No Cost
0472	Accession of tissue, gross exam, preparation and transmission of written report	No Cost
0473	Accession of tissue, gross and microscopic exam, preparation and transmission of written report	No Cost
0474	Accession of tissue, gross and microscopic exam, including assessment of surgical margins for presence of disease, prep and transmission of written report	No Cost

PREVENTIVE

Codes	Description	Patient Pays
1110	Prophylaxis – adult (Limit one (1) every six (6) months)	No Cost
1110	Prophylaxis – adult, additional	Full Cost
1120	Prophylaxis – child (Limit one (1) every six (6) months)	No Cost
1120	Prophylaxis – child, additional	Full Cost
1206	Topical application of fluoride varnish	No Cost
1208	Topical application of fluoride	No Cost
1330	Oral hygiene instructions	No Cost
1351	Sealant – per tooth	$20.00
1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	$45.00
1510	Space maintainer – fixed – unilateral	$95.00
1515	Space maintainer – fixed – bilateral	$90.00
1520	Space maintainer – removable – unilateral	$95.00
1525	Space maintainer – removable – bilateral	$90.00
1550	Re-cementation of space maintainer	No Cost
1555	Removal of fixed space maintainer	No Cost

RESTORATIVE

Codes	Description	Patient Pays
2140	Amalgam – one (1) surface, primary or permanent	No Cost
2150	Amalgam – two (2) surfaces, primary or permanent	No Cost
2160	Amalgam – three (3) surfaces, primary or permanent	No Cost
2161	Amalgam – four (4) or more surfaces, primary or permanent	No Cost
2330	Resin-based composite – one (1) surface, anterior	No Cost
2331	Resin-based composite – two (2) surfaces, anterior	No Cost
2332	Resin-based composite – three (3) surfaces, anterior	No Cost
2335	Resin-based composite – four (4) or more surfaces or involving incisal angle (anterior)	$85.00
2390	Resin-based composite crown, anterior	$75.00
2391	Resin-based composite – one (1) surface, posterior	$35.00
2392	Resin-based composite – two (2) surfaces, posterior	$45.00
2393	Resin-based composite – three (3) surfaces, posterior	$65.00
2394	Resin-based composite – four (4) or more surfaces, posterior	$75.00
2980	Crown repair necessitated by restorative material failure	$48.00
2981	Inlay repair necessitated by restorative material failure	$164.00
2982	Onlay repair necessitated by restorative material failure	$96.00

Patient Payment Schedule

CROWNS, all charges are per unit (each replacement or supporting tooth equals one (1) unit) [Replacement limit is one (1) every five (5) years]

Codes	Description	Patient Pays
2510	Inlay – metallic – one (1) surface	$245.00
2520	Inlay – metallic – two (2) surfaces	$245.00
2530	Inlay – metallic – three (3) or more surfaces	$245.00
2542	Onlay – metallic – two (2) surfaces	$300.00
2543	Onlay – metallic – three (3) surfaces	$300.00
2544	Onlay – metallic – four (4) or more surfaces	$300.00
2712	Crown – ¾ resin-based composite (indirect)	$355.00
2740	Crown – porcelain/ceramic substrate	$390.00
2750	Crown – porcelain fused to high noble metal	$380.00
2751	Crown – porcelain fused to predominantly base metal	$305.00
2752	Crown – porcelain fused to noble metal	$365.00
2780	Crown – ¾ cast high noble metal	$375.00
2781	Crown – ¾ cast predominantly base metal	$310.00
2782	Crown – ¾ cast noble metal	$370.00
2790	Crown – full cast high noble metal	$375.00
2791	Crown – full cast predominantly base metal	$305.00
2792	Crown – full cast noble metal	$370.00
2794	Crown – titanium	$355.00
2910	Recement inlay, onlay, or partial coverage restoration	No Cost
2915	Recement cast or prefabricated post and core	No Cost
2920	Recement crown	No Cost
2930	Prefabricated stainless steel crown – primary tooth	$65.00
2931	Prefabricated stainless steel crown – permanent tooth	$65.00
2932	Prefabricated resin crown	$75.00
2933	Prefabricated stainless steel crown with resin window	$135.00
2934	Prefabricated esthetic coated stainless steel crown – primary tooth	$130.00
2940	Protective restoration	No Cost
2950	Core buildup, including any pins	$100.00
2951	Pin retention – per tooth, in addition to restoration	$20.00
2952	Post and core in addition to crown, indirectly fabricated	$115.00
2954	Prefabricated post and core in addition to crown	$95.00
2960	Labial veneer (resin laminate) - chairside	$80.00

ENDODONTICS

Codes	Description	Patient Pays
3110	Pulp cap – direct (excluding final restoration)	No Cost
3120	Pulp cap – indirect (excluding final restoration)	No Cost
3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$75.00
3221	Pulpal debridement, primary and permanent teeth	$48.00
3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	$65.00
3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$17.00
3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$24.00
3310	Endodontic therapy, anterior tooth (excluding final restoration)	$135.00
3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$230.00
3330	Endodontic therapy, molar (excluding final restoration)	$325.00
3331	Treatment of root canal obstruction; non-surgical access	$80.00
3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$75.00
3333	Internal root repair of perforation defects	$75.00
3346	Retreatment of previous root canal therapy – anterior	$160.00
3347	Retreatment of previous root canal therapy – bicuspid	$285.00
3348	Retreatment of previous root canal therapy – molar	$390.00
3354	Pulpal regeneration – (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration	$50.00
3410	Apicoectomy/periradicular surgery – anterior	$190.00
3421	Apicoectomy/periradicular surgery – bicuspid (first root)	$190.00
3425	Apicoectomy/periradicular surgery – molar (first root)	$190.00
3426	Apicoectomy/periradicular surgery (each additional root)	$105.00
3430	Retrograde filling – per root	$40.00

Patient Payment Schedule

PERIODONTICS (Includes pre-operative and post-operative evaluations and treatment under a local anesthetic)

Codes	Description	Patient Pays
4210	Gingivectomy or gingivoplasty – four (4) or more contiguous teeth or tooth bounded spaces per quadrant	$140.00
4211	Gingivectomy or gingivoplasty – one (1) to three (3) contiguous teeth or tooth bounded spaces per quadrant	$65.00
4240	Gingival flap procedure, including root planing – four (4) or more contiguous teeth or tooth bounded spaces per quadrant	$170.00
4241	Gingival flap procedure, including root planing – one (1) to three (3) contiguous teeth or tooth bounded spaces per quadrant	$40.00
4245	Apically positioned flap	$170.00
4249	Clinical crown lengthening – hard tissue	$150.00
4260	Osseous surgery – (including flap entry and closure – four (4) or more contiguous teeth or tooth bounded spaces per quadrant)	$425.00
4261	Osseous surgery – (including flap entry and closure – one (1) to three (3) contiguous teeth or tooth bounded spaces per quadrant)	$175.00
4263	Bone replacement graft – first site in quadrant	$212.00
4264	Bone replacement graft – each additional site in quadrant	$106.00
4266	Guided tissue regeneration – resorbable barrier, per site	$305.00
4267	Guided tissue regeneration – nonresorbable barrier, per site (this includes membrane removal)	$350.00
4270	Pedicle soft tissue graft procedure	$235.00
4341	Periodontal scaling and root planing – four (4) or more teeth per quadrant	$65.00
4342	Periodontal scaling and root planing – one (1) to three (3) teeth per quadrant	$30.00
4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$65.00
4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$40.00
4910	Periodontal maintenance	$50.00

PROSTHODONTICS removable (dentures/partials) [Includes up to four (4) adjustments within first six (6) months after insertion; Replacement limit is one (1) every five (5) years]

Codes	Description	Patient Pays
5110	Complete denture – maxillary	$370.00
5120	Complete denture – mandibular	$370.00
5130	Immediate denture – maxillary	$365.00
5140	Immediate denture – mandibular	$365.00
5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$320.00
5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$320.00
5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$395.00
5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$395.00
5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$320.00
5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$320.00
5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$395.00
5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$395.00
5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	$360.00
5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	$360.00
5410	Adjust complete denture – maxillary	$20.00
5411	Adjust complete denture - mandibular	$20.00
5421	Adjust partial denture - maxillary	$20.00
5422	Adjust partial denture - mandibular	$20.00

REPAIRS TO PROSTHETICS

Codes	Description	Patient Pays
5510	Repair broken complete denture base	$70.00
5520	Replace missing or broken teeth – complete denture (each tooth)	$70.00
5610	Repair resin denture base	$70.00
5630	Repair or replace broken clasp – per tooth	$70.00
5640	Replace broken teeth – per tooth	$70.00
5650	Add tooth to existing partial denture	$70.00
5660	Add clasp to existing partial denture – per tooth	$70.00

DENTURE RELINING (limit one (1) every six (6) months)

Codes	Description	Patient Pays
5710	Rebase complete maxillary denture	$150.00
5711	Rebase complete mandibular denture	$150.00
5720	Rebase maxillary partial denture	$150.00
5721	Rebase mandibular partial denture	$150.00

Patient Payment Schedule

DENTURE RELINING (Continued) (limit one (1) every six (6) months)

Codes	Description	Patient Pays
5730	Reline complete maxillary denture (chairside)	$75.00
5731	Reline complete mandibular denture (chairside)	$75.00
5740	Reline maxillary partial denture (chairside)	$75.00
5741	Reline mandibular partial denture (chairside)	$75.00
5750	Reline complete maxillary denture (laboratory)	$130.00
5751	Reline complete mandibular denture (laboratory)	$130.00
5760	Reline maxillary partial denture (laboratory)	$130.00
5761	Reline mandibular partial denture (laboratory)	$130.00

INTERIM DENTURES (limit one (1) every five (5) years)

Codes	Description	Patient Pays
5810	Interim complete denture (maxillary)	$195.00
5811	Interim complete denture (mandibular)	$220.00
5820	Interim partial denture (maxillary)	$145.00
5821	Interim partial denture (mandibular)	$145.00
5992	Adjust maxillofacial prosthetic appliance, by report	$30.00
5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intra-oral) other than required adjustments, by report	$30.00

CROWNS, all charges are per unit (each replacement or supporting tooth equals one (1) unit) [Replacement limit one (1) every five (5) years]

Codes	Description	Patient Pays
6205	Pontic – indirect resin-based composite	$231.00
6210	Pontic – cast high noble metal	$370.00
6211	Pontic – cast predominantly base metal	$295.00
6212	Pontic – cast noble metal	$355.00
6214	Pontic – titanium	$350.00
6240	Pontic – porcelain fused to high noble metal	$375.00
6241	Pontic – porcelain fused to predominantly base metal	$305.00
6242	Pontic – porcelain fused to noble metal	$360.00
6245	Pontic – porcelain/ceramic	$390.00
6250	Pontic – resin with high noble metal	$219.00
6251	Pontic – resin with predominantly base metal	$217.00
6252	Pontic – resin with noble metal	$217.00
6545	Retainer – cast metal for resin bonded fixed prosthesis	$137.50
6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	$150.00
6740	Retainer crown – porcelain/ceramic	$390.00
6750	Retainer crown – porcelain fused to high noble metal	$380.00
6751	Retainer crown – porcelain fused to predominantly base metal	$305.00
6752	Retainer crown – porcelain fused to noble metal	$365.00
6780	Retainer crown – ¾ cast high noble metal	$410.00
6781	Retainer crown – ¾ cast predominantly base metal	$365.00
6782	Retainer crown – ¾ cast noble metal	$395.00
6790	Retainer crown – full cast high noble metal	$375.00
6791	Retainer crown – full cast predominantly base metal	$300.00
6792	Retainer crown – full cast noble metal	$365.00
6794	Retainer crown – titanium	$355.00
6930	Recement fixed partial denture	No Cost
6980	Fixed partial denture repair necessitated by restorative material failure	$118.00

ORAL SURGERY (includes routine pre-operative and post-operative evaluation and treatment)

Codes	Description	Patient Pays
7111	Extraction, coronal remnants – deciduous tooth	$22.00
7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of the tooth; and including elevation of mucoperiosteal flap, if indicated	$65.00
7220	Removal of impacted tooth – soft tissue	$50.00
7230	Removal of impacted tooth – partially bony	$90.00
7240	Removal of impacted tooth – completely bony	$140.00
7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$135.00
7250	Surgical removal of residual tooth roots (cutting procedure)	$65.00
7251	Coronectomy – intentional partial tooth removal	$125.00

Patient Payment Schedule

ORAL SURGERY (Continued) (includes routine pre-operative and post-operative evaluation and treatment)

Codes	Description	Patient Pays
7260	Oroantral fistula closure	$160.00
7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	No Cost
7280	Surgical access of an unerupted tooth	No Cost
7283	Placement of device to facilitate eruption of impacted tooth	No Cost
7285	Biopsy of oral tissue – hard (bone, tooth)	$105.00
7286	Biopsy of oral tissue – soft	$80.00
7295	Harvest of bone for use in autogenous grafting procedure	$95.00
7310	Alveoloplasty in conjunction with extractions – four (4) or more teeth or tooth spaces, per quadrant	$70.00
7311	Alveoloplasty in conjunction with extractions – one (1) to three (3) teeth or tooth spaces, per quadrant	$65.00
7320	Alveoloplasty not in conjunction with extractions – four (4) or more teeth or tooth spaces, per quadrant	$95.00
7321	Alveoloplasty, not in conjunction with extractions – one (1) to three (3) teeth or tooth spaces, per quadrant	$85.00
7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	No Cost
7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	No Cost
7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
7510	Incision and drainage of abscess – intraoral soft tissue	No Cost
7511	Incision and drainage of abscess – intraoral soft tissue – complicated (drainage of multiple facial spaces)	No Cost
7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	No Cost
7963	Frenuloplasty	No Cost

EMERGENCY VISIT

Codes	Description	Patient Pays
9110	Palliative (emergency) treatment of dental pain – minor procedure	No Cost

GENERAL ANESTHESIA/IV SEDATION (covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on this Patient Payment Schedule.)

Codes	Description	Patient Pays
9223	Deep sedation/general anesthesia – each fifteen (15) minute increment	$70.00
9243	Intravenous moderate (conscious) sedation/analgesia – each fifteen (15) minutes	$50.00

MISCELLANEOUS SERVICES

Codes	Description	Patient Pays
9940	Occlusal guard, by report	$175.00
9942	Repair and/or reline of occlusal guard	$155.00
9943	Occlusal guard adjustment	$155.00
9951	Occlusal adjustment – limited	$45.00
9952	Occlusal adjustment - complete	$135.00

Orthodontics is covered at 50% with a lifetime maximum benefit of $1,000 per eligible employee or spouse, or dependents to age nineteen (19).

The maximum payment for all covered dental procedures for each Eligible Person in any one (1) calendar year is $1,000.

Partial Listing of Limitations & Exclusions of Benefits

The Benefits as outlined are subject to the following limitations:

1. Cleanings, including periodontal cleanings, are limited to one (1) every six (6) months. Bitewing x-rays for children are limited to one (1) each six (6) months and, for adults, one (1) each year.
2. Full upper and/or lower dentures are not to exceed one (1) each in any five (5) year period.
3. Full mouth x-rays are limited to one (1) every three (3) years.
4. Restorations on the same surface of the same tooth are covered once (1) in a two (2) year period.
5. Emergency services received from any dentist other than an In-Network provider are limited to $50.00.

The following services are excluded from this program:

1. Any service that is not specifically listed as a covered expense.
2. Cosmetic dental care.
3. Dental conditions arising out of and because of your employment or for which Worker's Compensation is payable; or services which are provided to you by a government agency.
4. Treatment required by reason of war.
5. Dental services performed in a hospital and related hospital fees.
6. Treatment of fractures and dislocations.
7. Loss or theft of fixed and removable prosthetic (crowns, bridges, full or partial dentures).
8. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
9. Congenital malformations.
10. Cysts and malignancies.
11. Prescription drugs and other medications.
12. Accidental injury, which is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.
13. Cases where, in the professional judgment of the attending dentist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded.
14. "Specialist consultations" for non-covered benefits.
15. Implant placement or removal, appliances placed on or services associated with implant.

Frequently Asked Questions

Q. **Do I have to pay the dentist at the time of my visit?**
A. *The patient co-payments and non-covered services should be handled in accordance with the dentist's normal billing practices. The amounts you are responsible for are identified on the Patient Payment Schedule.*

Q. **After my effective date of coverage, is there a waiting period before I can see the dentist?**
A. *No. Once you become eligible, call a dentist from the directory of PPO providers. However, appointments are subject to availability.*

Q. **Once I've selected a dental provider, may I change dentists?**
A. *Yes. You may change from one PPO provider to another at any time, for any reason. It is not necessary to notify Delta Dental of Kansas.*

Q. **Does the PPO Program provide coverage for specialty services?**
A. *Should you require specialty services, talk to your dentist. Your dentist will provide these services or refer you to a specialist for specific procedures. The specialist must be a PPO provider in order to receive benefits.*

Q. **What is an In-Network Dentist?**
A. *A dentist who is listed in the PPO directory who may have signed a supplement to a participation agreement and agrees to accept the amount in a fee schedule set by Delta Dental.*

Q. **Are there any claim forms or pre-treatment authorization forms that must be filled out in order to receive benefits?**
A. *No. Your participating dentist will file claims on your behalf directly to Delta Dental of Kansas.*

Q. **What if I have an emergency and my dentist is not available?**
A. *You may call any participating PPO dentist. You may also see any licensed dentist in the event of an emergency, but you will be responsible for any charges over $50.00.*

Q. **What services are available on the Delta Dental website?**
A. *Visit our website, www.deltadentalks.com to locate a participating PPO dentist, find information about your eligibility and benefit plan, and print yourself an ID card.*