Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 5866-6027, 9027 - IAFF
City of Columbus

This Summary of Dental Plan Benefits should be read along with your collectively bargained contract and City of Columbus Benefits Booklet. Your collectively bargained contract and City of Columbus Benefits Booklet provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the collectively bargained contract and City of Columbus Benefits Booklet, the statement in this Summary applies to you and you should ignore the conflicting statement in the collectively bargained contract and City of Columbus Benefits Booklet. The percentages below are applied to Delta Dental’s allowance for each service and it may vary due to the dentist’s network participation.*

Control Plan – Delta Dental of Ohio

Benefit Year – January 1 through December 31

Covered Services –

<table>
<thead>
<tr>
<th></th>
<th>Delta Dental PPO Dentist</th>
<th>Delta Dental Premier Dentist</th>
<th>Nonparticipating Dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic and Preventive Services</strong> – exams, cleanings, fluoride, and space maintainers</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Emergency Palliative Treatment</strong> – to temporarily relieve pain</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Brush Biopsy</strong> – to detect oral cancer</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Radiographs</strong> – X-rays</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Basic Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sealants</strong> – to prevent decay of permanent teeth</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Minor Restorative Services</strong> – fillings and crown repair</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Endodontic Services</strong> – root canals</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Periodontic Services</strong> – to treat gum disease</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Oral Surgery Services</strong> – extractions and dental surgery</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Major Restorative Services</strong> – crowns</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Other Basic Services</strong> – misc. services</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Relines and Repairs</strong> – to prosthetic appliances</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Major Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prosthodontic Services</strong> – bridges, dentures, and crowns over implants</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Implants</strong> – endosteal implants to replace missing teeth</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Orthodontic Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orthodontic Age Limit</strong> – treatment must begin prior to age 19 and coverage will continue to the end of treatment or until the maximum has been reached</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
</tr>
</tbody>
</table>

* When you receive services from a Nonparticipating Dentist, the percentages in this column 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 or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice in any period of 12 consecutive months.
- Prophylaxes (cleanings) are payable twice in any period of 12 consecutive months. Benefits for periodontal maintenance procedures are unlimited.
- Fluoride treatments are payable twice in any period of 12 consecutive months with no age limit.
- Space maintainers are payable once per area per lifetime for people age 18 and under.
- Bitewing X-rays are payable twice in any period of 12 consecutive months and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Sealants are payable for first and second permanent molars and bicuspid for people age 18 and under. The surface must be free from decay and restorations.
Composite resin (white) restorations are Covered Services on posterior teeth.
Metallic inlays are Covered Services.
Covered people under 17 years of age will receive stainless steel or prefabricated crowns only.
Surgical periodontic services are payable first by the medical carrier, then will be a Covered Service under this plan secondary to medical.
Most oral surgical services are payable first by the medical carrier, then will be a Covered Service under this plan, secondary to medical.
Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.
Limited and complete occlusal adjustments are not Covered Services. Antibiotic drug injections are Covered Services.
X-rays taken for the purpose of Orthodontic evaluation will be paid at the Orthodontic benefit level.
Diagnostic casts and photographs taken for the purpose of Orthodontic evaluation will be paid at the Orthodontic benefit level.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

**Maximum Payment** – $1,500 per person total per Benefit Year on all services except orthodontic services.  $1,850 per person total per lifetime on orthodontic services.

**Payment for Orthodontic Service** – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental’s stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 75% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by your Dentist to Delta Dental.

**Deductible** – None.

Also eligible are your Spouse and your Children to the end of the calendar year in which they turn 26, including your Children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled.

Enrollees and dependents choosing this dental plan are required to remain enrolled for a minimum of 12 months. Should an Enrollee or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Enrollee is enrolled (except under COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

**Coordination of Benefits** – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled as both an Enrollee on your own application and as a Dependent on your Spouse’s application. Your Dependent Children may be enrolled on both your and your Spouse’s applications as well. Delta Dental will coordinate benefits between your coverage and your Spouse’s coverage.

Benefits will cease on the last day of the month in which the employee is terminated.
This plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. This plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

This plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats)

This plan provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, call 1-800-524-0149 (TTY users call 711).

If you believe that this plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with the civil rights coordinator at PO Box 9089, Farmington Hills, MI 48333-9089; by phone at 1-800-524-0149 (TTY users call 711) or fax to 517-706-3513. You can file a grievance by mail, fax or phone. If you need help filing a grievance, the civil rights coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201; 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-800-524-0149 (ATS: 711).


ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए मै.शुल्क उपलब्ध हैं। कॉल करें 1-800-524-0149 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-524-0149 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-800-524-0149 (TTY: 711 まで, お電話にてご連絡ください。)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-524-0149 (TTY: 711) 번으로 전화해 주십시오.


UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-524-0149 (TTY: 711).

ATENŢIE: Dacă vorbiţi limba română, vă stau la dispoziţie servicii de asistenţă lingvistică, gratuit. Sunaţi la 1-800-524-0149 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-524-0149 (телетайп: 711).


ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-524-0149 (TTY: 711).

يرجي الانتباه: إذا كنت تتحدث اللغة العربية السورية، تتوفر لك خدمات المساعدة اللغوية المجانية. يرجى الاتصال بالرقم: 1-800-524-0149

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-524-0149 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-524-0149 (телетайп: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-524-0149 (TTY: 711).