<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Primary enrollee, spouse (includes domestic partner) and eligible dependent children to the end of the month dependent turns age 26</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$50 per person / $150 per family each calendar year</td>
</tr>
<tr>
<td>Deductibles waived for Diagnostic &amp; Preventive (D &amp; P) and Orthodontics?</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| Maximums                                                                  | **Silver Plan:** $3,000 per person each calendar year  
**Gold Plan:** $5,000 per person each calendar year                                                                                 |
| D & P counts toward maximum                                              | Yes                                                                                                                                 |
| Waiting Period(s)                                                         | Basic Services: None  
Major Services: None  
Prosthodontics: None  
Orthodontics: None                                                    |

| Benefits and Covered Services*                                             | Delta Dental PPO dentists†  
Delta Dental Premier dentists†  
Non-Delta Dental dentists†  
Delta Dental PPO dentists†  
Delta Dental Premier dentists†  
Non-Delta Dental dentists† |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| **Diagnostic & Preventive Services (D & P)**                              | 100 %  
100 %  
100 %  
100 %  
100 %  
100 % |
| Exams, cleanings and x-rays                                               |                                                                                                                                 |
| **Basic Services**                                                        | 90 %  
80 %  
80 %  
90 %  
90 %  
90 % |
| Fillings, posterior composites, crown/linlay/only recementation, denture repair/relines and sealants |                                                                                                                                 |
| **Endodontics (root canals)**                                             | 90 %  
80 %  
80 %  
90 %  
90 %  
90 % |
| Covered Under Basic Services                                              |                                                                                                                                 |
| **Periodontics (gum treatment)**                                         | 90 %  
80 %  
80 %  
90 %  
90 %  
90 % |
| Covered Under Basic Services                                              |                                                                                                                                 |
| **Oral Surgery**                                                          | 90 %  
80 %  
80 %  
90 %  
90 %  
90 % |
| Covered Under Basic Services                                              |                                                                                                                                 |
| **Major Services**                                                        | 60 %  
50 %  
50 %  
60 %  
60 %  
60 % |
| Crowns, inlays, onlays and cast restorations                              |                                                                                                                                 |
| **Prosthodontics**                                                        | 60 %  
50 %  
50 %  
60 %  
60 %  
60 % |
| Bridges and dentures                                                      |                                                                                                                                 |
| **Orthodontic Benefits**                                                  | 50 %  
50 %  
50 %  
50 %  
50 %  
50 % |
| Dependent children                                                        |                                                                                                                                 |
| **Orthodontic Maximums**                                                  | $3,000 Lifetime  
$3,000 Lifetime  
$3,000 Lifetime  
$3,000 Lifetime  
$3,000 Lifetime  
$3,000 Lifetime |

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist’s actual fees.  
† Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and the program allowance for non-Delta Dental dentists.

**Delta Benefit Highlights for:** Monroe County Board of County Commissioners  
**Group No:** 17858

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This benefit information is not intended or designed to replace or serve as the plan’s Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company’s benefits representative.