

CITY OF PITTSBURGH

GROUP NO: 17974



Basic Plan

ELIGIBILITY	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26			
Deductibles	None			
Maximums D&P counts toward maximum?	\$1,200 per person each calendar year			
	Yes			
Waiting Period(s)	Basic Benefits	Major Benefits	Prosthodontics	Orthodontics
	None	None	None	None
Orthodontic Benefits ¹ Dependent children	50%			
Orthodontic Maximums	\$600 Lifetime			

SAMPLE BENEFITS AND COVERED SERVICES ¹	TABLE ALLOWANCE ^{2, 3} (Amount Delta Dental Will Pay)
Diagnostic & Preventive Services (D&P)	D0120 Periodic oral exam – established patient: \$15 D0272 Bitewings (two diagnostic images): \$15 D1110 Prophylaxis (cleaning): \$25
Basic Services	D2150 Amalgam fillings, two surfaces – primary or permanent: \$36 D2160 Amalgam fillings, three surfaces – primary or permanent: \$47
Endodontics	D3310 Root canal (anterior – excluding final restoration): \$138
Periodontics	D4341 Periodontal scaling and root planing – four or more teeth per quadrant: \$33
Oral Surgery	D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal): \$30
Major Services	D2750 Crown; porcelain fused to high noble metal: \$225
Prosthodontics	D5110 Complete denture – maxillary: \$230
Implants	D6050 Surgical placement – transosteal implant: \$1,053

¹ Limitations or waiting periods may apply for some benefits; some services may be excluded.

² Allowances specified above represent only a few examples from your plan's table. Please refer to your Benefit Booklet for a full schedule of allowances and for any limitations and exclusions on these benefits.

³ Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and 90th percentile for non-Delta Dental dentists.

Enhanced & Premier Plan

ELIGIBILITY	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26			
Deductibles	None			
Maximums D&P counts toward maximum?	Enhanced Plan \$1,000 per person each calendar year Premier Plan \$1,500 per person each calendar year			
	Yes			
Waiting Period(s)	Basic Benefits	Major Benefits	Prosthodontics	Orthodontics
	None	None	None	None

BENEFITS AND COVERED SERVICES ⁴	Enhanced Plan		Premier Plan	
	Delta Dental PPO dentist ⁵	Non-Delta Dental PPO dentist ⁵	Delta Dental PPO dentist ⁵	Non-Delta Dental PPO dentist ⁵
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100%	100%	100%	100%
Basic Services Fillings	100%	100%	100%	100%
Endodontics (root canals) Covered Under Basic Services	100%	100%	100%	100%
Periodontics (gum treatment) Covered Under Major Services	50%	50%	50%	50%
Oral Surgery Covered Under Basic Services	100%	100%	100%	100%
Denture relining/rebasing	50%	50%	50%	50%
Major Services Crowns, inlays, onlays and cast restorations	50%	50%	50%	50%
Prosthodontics Bridges, dentures and implants	50%	50%	50%	50%
Orthodontic Benefits Dependent children	50%	50%	50%	50%
Orthodontics Maximums	\$800 Lifetime	\$800 Lifetime	\$2,000 Lifetime	\$2,000 Lifetime

⁴ 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.

⁵ Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and 90th percentile for non-Delta Dental dentists.

LIST OF PRIMARY COVERED SERVICES AND LIMITATIONS

Basic Plan

D&P Services	How Many How Often
Prophylaxis (cleanings)	• Twice in a calendar year
Oral Examinations	• Twice in a calendar year
Topical Fluoride Application	• To age 24 — 2 times in 1 calendar year
X-rays	(Bitewing 2 times in 1 calendar year; Full Mouth/Panorex 1 time in 3 calendar years)
Space Maintainers	To age 24
Fillings	1 in 24 months
Simple Extractions	Refer to fee schedule
Endodontics	Refer to fee schedule
Oral Surgery	Refer to fee schedule
General Anesthesia	Refer to fee schedule
Crowns/Inlays/Onlays	1 in 60 months
Basic Services	How Many How Often
Consultations	Refer to fee schedule
Scalings	Refer to fee schedule
Root Canal Treatment	Refer to fee schedule
Periodontic/Perio Cleaning	Refer to fee schedule
Bridges	1 time in 60 months
Dentures	1 time in 60 months
Recementing	Refer to fee schedule
Implants	1 time in 60 months
Orthodontic Benefits	How Many How Often
	Refer to fee schedule

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.

Enhanced & Premier Plan

D&P Services	How Many How Often
Prophylaxis (cleanings)	• Twice in a calendar year
Oral Examinations	• Twice in a calendar year
Topical Fluoride Application	• Two fluoride treatment per calendar year for dependent children up to 19th birthday.
X-rays	• Full mouth X-rays: one per 36 months • Bitewing X-rays: 1 in 6 months
Space Maintainers	• Space Maintainers for dependent children up to 19 th birthday.
Fillings	• 1 in 24 months
Simple Extractions	• Once per lifetime
Endodontics	• Root canal treatment limited to once per tooth per 24 months.
General Anesthesia	• When dentally necessary in connection with oral surgery, extractions or other covered dental services.
Crowns/Inlays/Onlays	
Basic Services	How Many How Often
Crown, Denture and Bridge Repair/Recommendations	• 1 in 60 months
Periodontics	• Periodontal scaling and root planing once per quadrant, every 24 months. • Periodontal surgery once per quadrant, every 36 months. • Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year.
Implants	• 1 in 60 months
Bridges and Dentures	• Initial placement to replace one or more natural teeth, which are lost while covered by the plan • Dentures and bridgework replacement: one every 60 months. • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed.
Orthodontic Benefits	How Many How Often
	• Your Children, up to age 26, are covered while Dental Insurance is in effect. You, Your Spouse, and Your Children, up to age 26, are covered while Dental Insurance is in effect.