

Benefits for Pittsylvania County & Schools
Comprehensive Plan
Account Number: 6363
Effective Date: October 1, 2020

Annual Deductible (<i>Applies to Basic and Major Services</i>)	\$50 per person; \$150 per family, per contract year
Annual Maximum	\$1,000 per enrollee, per contract year
Healthy Smile, Healthy You® Program	Your plan provides additional cleanings and/or application of topical fluoride to enrollees with specific health conditions such as pregnancy, diabetes, high-risk cardiac conditions or who are undergoing cancer treatment via chemotherapy and/or radiation. Enrollment in Healthy Smile, Healthy You® is simple. Visit DeltaDentalVA.com to print an enrollment form.

Covered Benefits					
Delta Dental will pay the stated percentage of the plan allowance based on the dentist's participation with Delta Dental.					
Coverage	Coinsurances			Benefit Limitations	Benefit Waiting Period
	In-Network		Out-of-Network		
	PPO	Premier			
Diagnostic and Preventive Services	100%	100%	100%		None
<ul style="list-style-type: none"> Oral exams and cleanings Periodontal cleaning Fluoride applications Bitewing X-rays Full mouth/panelpipse X-rays Sealants Space maintainers 				Twice in a 12 consecutive month period. Twice in a 12 consecutive month period. Twice in a 12 consecutive month period for enrollees under the age of 19. Bitewing X-rays are limited to once in a 12 consecutive month period limited to a maximum of 4 films or a set (7-8 films) of vertical bitewings. Once in a 3-year period. One application per tooth for enrollees under the age of 16 on non-carious, non-restored 1 st and 2 nd permanent molars. Once per quadrant per arch for enrollees under the age of 14.	
Basic Services	80%	80%	80%		None
<ul style="list-style-type: none"> Amalgam (silver) and composite (white) fillings Stainless steel crowns Simple extractions Endodontic services/root canal therapy Periodontic services Complex oral surgery Denture repair and recementation of crowns, bridges and dentures 				Once per surface in a 24-month period; Composite (white) fillings are limited to the upper and lower 6 front teeth. Primary (baby) teeth for enrollees under the age of 14. Retreatment only after 24 months from initial root canal therapy treatment. Once per quadrant in a 24-36 month period based on services rendered. Surgical extractions and other surgical procedures. Once in a 12-month period after 6 months from initial placement.	

Covered Benefits

Delta Dental will pay the stated percentage of the plan allowance based on the dentist's participation with Delta Dental.

Coverage	Coinsurances			Benefit Limitations	Benefit Waiting Period
	In-Network		Out-of-Network		
	PPO	Premier			
Major Services	50%	50%	50%		None
<ul style="list-style-type: none"> • Crowns • Prosthodontics, removable and fixed • Implants 				Once per tooth in a 60-month period for enrollees age 12 and older. Once in a 60-month period for enrollees age 16 and older. Once per site for enrollees age 16 and older.	

COVERAGE IS AVAILABLE FOR

- Enrollee and spouse
- Dependent children, only to the end of the month they reach age 26 (the "limiting age").
-

CHOOSING A DENTIST

You may select the dentist of your choice. However, to get the full advantage of your Delta Dental coverage, you should choose a dentist who participates in the Delta Dental network(s) covered by your plan.

Delta Dental PPO™ and Delta Dental Premier® dentists have agreed to accept Delta Dental's plan allowance, plus any required coinsurance and deductible (if applicable) as payment in full. In addition, Delta Dental PPO™ and Delta Dental Premier® dentists will submit claims directly to Delta Dental and we will issue the payment to the dentist.

Non-Participating dentists have not agreed to accept Delta Dental's plan allowance as full payment. After Delta Dental pays its portion of the bill, you are responsible for any required coinsurance and deductible (if applicable), as well as the difference between the non-participating dentist's charge and Delta Dental's payment. Payment will be made to you, unless state law requires otherwise.

The chart below illustrates how choosing a network dentist may help you save on out-of-pocket costs.

	PPO Network Dentist	Premier Network Dentist	Non-Participating Dentist
Dentist's Charge for Covered Procedure	\$215.00	\$215.00	\$215.00
Delta Dental's Plan Allowance	\$126.00	\$169.00	\$113.00
Coinsurance Percentage	80%	80%	80%
Delta Dental's Payment	\$100.80	\$135.20	\$90.40
Patient Payment*	\$25.20	\$33.80	\$124.60

The example shown is for illustrative purposes only. Payment structures may vary between plans.

The preceding information is a brief description of the services covered under your plan. It is not intended for use as a summary plan description nor is it designed to serve as an Evidence of Coverage. If you have specific questions regarding benefit structure, limitations or exclusions, consult the plan document or call Delta Dental's Benefit Services Department at 800-237-6060.