DELTA DENTAL®

# Delta Dental PPO plus Premier™

Benefits for Pittsylvania County & schools
Comprehensive Plan
Group Number: 6363
Effective Date: October 1, 2019

| | |
|---|---|
| **Annual Deductible** *(Applies to Basic and Major Services)* | $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 the ***Healthy Smile, Healthy You* Program** 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 |
| • Oral exams and cleanings | | | | Twice in a 12 consecutive month period. | |
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| • Fluoride applications | | | | Once in a 12 consecutive month period for enrollees under the age of 19. | |
| • Bitewing X-rays | | | | 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. | |
| • Full mouth/panelipse X-rays | | | | Once in a 3-year period. | |
| • Sealants | | | | One application per tooth for enrollees under the age of 16 on non-carious, non-restored 1st and 2nd permanent molars, once in 5 years. | |
| • Space maintainers | | | | Once per quadrant per arch for enrollees under the age of 14. | |
| **Basic Services** | 80% | 80% | 80% | | None |
| • Amalgam (silver) and composite (white) fillings | | | | Once per surface in a 24-month period; Composite (white) fillings are limited to the upper and lower 6 front teeth. | |
| • Stainless steel crowns | | | | Primary (baby) teeth for enrollees under the age of 14. | |
| • Simple extractions | | | | | |
| • Endodontic services/root canal therapy | | | | Retreatment only after 24 months from initial root canal therapy treatment. | |
| • Periodontic services | | | | Once per quadrant in a 24-36 month period based on services rendered. | |
| • Complex oral surgery | | | | Surgical extractions and other surgical procedures. | |
| • Denture repair and recementation of crowns, bridges and dentures | | | | Once in a 12-month period after 6 months from initial placement. | |

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| | In-Network | | Out-of-Network | | |
| | PPO | Premier | | | |
| **Major Services**<br>• Crowns<br>• Prosthodontics, removable and fixed | 50% | 50% | 50% | Once per tooth in a 60-month period for enrollees age 12 and older.<br>Once in a 60-month period for enrollees age 16 and older. | None |

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. Please visit DeltaDentalVA.com to find a participating dentist in your area.

The following chart illustrates how choosing a network dentist helps 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.*