



# HANOVER COUNTY GOVERNMENT HANOVER COUNTY PUBLIC SCHOOLS PAMUNKEY REGIONAL JAIL PAMUNKEY REGIONAL LIBRARY

Effective January 1, 2021

## Delta Dental PPO™ — EPO Plan Design

With the Delta Dental PPO™-EPO Plan Design (“EPO Plan”), you will know prior to treatment what you will have to pay for covered benefits. This aids in better financial planning for you and your family. A Delta Dental PPO dentist must provide services for covered benefits. In almost all cases, services rendered by a dentist that is not in the Delta Dental PPO network are not covered. There is one exception. You may receive covered benefits from a dentist that is not in the Delta Dental PPO network if the covered benefit(s) are emergency services and you are at least 35 miles from a Delta Dental PPO dentist’s office. However, your benefit maximum for all emergency services provided by a dentist that is not in the Delta Dental PPO network is limited to \$50 per benefit period. Emergency services are covered benefits that require immediate attention to alleviate severe pain, swelling, bleeding or to avoid serious jeopardy to your health.

Delta Dental PPO dentists have agreed to accept Delta Dental’s payment and your copayment as payment in full for covered benefits. Refer to the attached **Schedule of Benefits and Copayments** for more details about what is covered under your plan. Delta Dental PPO dentists will submit claims directly to Delta Dental and we will issue the payment to the dentist. Please visit [DeltaDentalVA.com](http://DeltaDentalVA.com) to find a participating dentist in your area. The toll-free phone number for questions about your Delta Dental PPO™-EPO Plan coverage is 800-237-6060.

## Delta Dental High and Low Plan

The High Plan and Low Plan offered by Delta Dental have an exciting feature that can offer substantial savings. Services are available from dentists in two networks – Delta Dental PPO and Delta Dental Premier. Which networks, if any, your dentist is in determines your out-of-pocket costs when you visit the dentist. If your dentist participates in the Delta Dental PPO network, you will be charged less for services than if your dentist participates in the Delta Dental Premier network. If your dentist does not participate in either network, you will still have coverage but will have to pay more of the cost yourself.

To use the plans, just call the dental office of your choice and make an appointment. If you go to a network dentist, he/she will complete and submit claim forms directly to Delta Dental and Delta Dental will then pay that dentist directly. If you go to an out-of-network dentist, you are responsible for the dentist’s entire bill and Delta Dental will reimburse you directly unless an assignment of benefits is made to the dentist.

If you visit a **Delta Dental PPO or Delta Dental Premier** network dentist, payment is based on the lowest of:

- (1) the fee the dentist bills Delta Dental
- (2) the most recent fee for the service that the dentist has on file with Delta Dental
- (3) the PPO or Premier payment allowance used by the Delta Dental in the state in which the dental service is provided.

If you visit an **out-of-network** dentist, payment is based on the lowest of:

- (1) the fee the dentist bills Delta Dental
- (2) the plan allowance used by the Delta Dental in the state in which the dental service is provided.

In all cases, Delta Dental determines the plan allowance. Payments for out-of-network dentists’ services may be lower than payment allowances for network dentists’ services. Delta Dental PPO and Delta Dental Premier dentists have agreed to accept Delta Dental allowances as payment in full for covered benefits. This means that you pay only the deductible and coinsurance for these services.

An important advantage of the Delta Dental High and Low Plans is that you may go to any dentist you choose\*

\* Non-participating dentists have not agreed to accept plan allowances as payment in full for their services. This means that you pay the deductibles, coinsurance, and the differences between the non-participating dentists’ charges and the plan allowances for covered benefits. The amount you would owe a non-participating dentist may be higher than the amount you would owe a participating dentist for the same covered benefit.

# PROGRAM COMPARISON

Plan Features	Delta Dental PPO™-EPO Plan Design	Delta Dental High Plan	Delta Dental Low Plan
<b>Annual Deductible</b>			
<ul style="list-style-type: none"> <li>Diagnostic &amp; Preventive Services</li> <li>Basic and Major Services</li> </ul>	<p>No deductible</p> <p>No deductible</p>	<p>No deductible</p> <p>\$50 per patient per calendar year; \$150 per family unit</p>	<p>No deductible</p> <p>\$ 50 per patient per calendar year; \$150 per family unit</p>
<b>Annual Benefit Maximum</b>	\$2,000 per patient per calendar year	\$1,500 per patient per calendar year	\$1,000 per patient per calendar year
<b>Benefits</b>	<b>In-Network Delta Dental PPO</b>	<b>Plan Pays</b>	<b>You Pay</b>
<ul style="list-style-type: none"> <li>Diagnostic &amp; Preventive Services (Exams, cleanings, x-rays)</li> <li>Basic Services (Fillings, oral surgery, endodontics, periodontics)</li> <li>Major Services (Crowns, bridges, dentures. Implants are covered under the Delta Dental High Plan only.) <i>Major Services Waiting Period</i></li> <li>Orthodontic Services <i>Orthodontic Services Waiting Period</i></li> </ul>	<p>Fixed Copayment</p> <p>Fixed Copayment</p> <p>Fixed Copayment</p> <p><i>No Waiting Period</i></p> <p>50% Plan Allowance</p> <p><i>No Waiting Period</i></p>	<p>100% Plan Allowance</p> <p>80% Plan Allowance (after deductible)</p> <p>50% Plan Allowance (after deductible)</p> <p>6 months from your effective date**</p> <p>50% Plan Allowance</p> <p>6 months from your effective date**</p>	<p>0% Plan Allowance</p> <p>20% Plan Allowance (after deductible)</p> <p>20% Plan Allowance (after deductible)</p> <p>Not Covered</p> <p>Not Covered</p>
<b>Lifetime Orthodontic Maximum</b>	\$2,000 lifetime maximum per patient	\$1,000 lifetime maximum per patient	N/A
<b>Dentist Network</b>	A Delta Dental PPO dentist must be utilized for care. In almost all cases, services rendered by a dentist that is not in the Delta Dental PPO network are not covered.	Choose any dentist or specialist, but your out of pocket cost is lowest with a Delta Dental PPO participating dentist.	Choose any dentist or specialist, but your out of pocket cost is lowest with a Delta Dental PPO participating dentist.
<b>Semi-Monthly Rates</b>			
<ul style="list-style-type: none"> <li>Employee Only</li> <li>Employee/Child</li> <li>Employee/Spouse or 2 Children</li> <li>Employee/Family</li> </ul>	<p>\$14.32</p> <p>\$24.87</p> <p>\$26.36</p> <p>\$35.89</p>	<p>\$18.15</p> <p>\$31.20</p> <p>\$36.68</p> <p>\$60.49</p>	<p>\$12.34</p> <p>\$21.22</p> <p>\$24.95</p> <p>\$44.67</p>
<b>Benefit/Membership Services</b>	1-800-237-6060	1-800-237-6060	1-800-237-6060

**\*\*High Plan Major Services Waiting Period:** New Hires – Waiting period is waived for Major services and credit may be given towards Orthodontic waiting period with proof of prior coverage. Existing Employees - Credit may be given towards Major services and Orthodontic waiting periods with proof of continuous coverage.

# Hanover County Dental Plan Options

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## Questions & Answers

### 1. Are there any benefit changes in the Delta Dental plans this year?

Yes, the Delta Dental of Virginia High Plan will have a \$1,500 annual benefit maximum per enrollee, per calendar year, effective January 1, 2021.

### 2. What is the difference between the Delta Dental PPO™-EPO Plan Design and the High and Low plans?

The Delta Dental PPO™-EPO Plan Design (“EPO Plan”) uses the Delta Dental PPO network exclusively. There are no out-of-network benefits, so you must visit a Delta Dental PPO dentist for your dental care. This very large network is local, statewide and national. The EPO Plan is a fixed copayment plan with the exception of orthodontic services, which will be covered by coinsurance (a percentage of your charges) rather than by copayment. The EPO Plan allows you to reference your **Schedule of Benefits and Copayments** to know exactly what you will be paying for Diagnostic & Preventive, Basic and Major services.

The Delta Dental High and Low plans allow you to select a dentist of your choice. When you have covered dental services, you are responsible for a percentage of your charges (coinsurance) rather than a set copayment. Under the Delta Dental High and Low plans you have coverage if you go to a dentist who does not participate with Delta Dental, but your costs are less if you go to a dentist who does participate with Delta Dental.

### 3. Will I need to fill out a new enrollment form for the dental plan?

You will need to complete an enrollment form only if you are a new enrollee, or if you are making changes to your current coverage. If you wish to remain in the plan and tier level (employee, employee + spouse, family, etc.) you are currently enrolled under, you will not need to fill out a new enrollment form.

### 4. How can I find out if my dentist participates with Delta Dental?

- ❖ Check Delta Dental’s website at [www.deltadentalva.com](http://www.deltadentalva.com).
- ❖ Call Delta Dental’s Benefit Services Representatives.  
Enrollees may call 1-800-237-6060.  
Representatives are available Monday – Thursday 8:15 a.m. - 6:00 p.m. EST and Friday 8:15 a.m. - 4:45 p.m. EST.
- ❖ Ask your dentist if he/she is a participating dentist with Delta Dental PPO or Premier network.

### 5. Will I receive an ID card?

- ❖ New ID cards will be issued for new enrollees and enrollees who are switching plans or making a tier change.
- ❖ If you need a replacement card you can call Delta Dental’s Benefit Services to order new cards at 1-800-237-6060 or you can print a replacement card by visiting our website at [www.deltadentalva.com](http://www.deltadentalva.com).

### 6. How can my dentist enroll in the network?

Have the dentist contact Delta Dental’s Provider Relations Department at 1-800-237-6060.

### 7. How can I avoid unexpected charges for dental care?

- ❖ See a Delta Dental participating dentist.
- ❖ File a pre-determination (not required but recommended for services over \$250).
- ❖ Call Delta Dental’s Benefit Services Representatives for clarification regarding any benefit questions.

## 8. What will happen if I go out of network?

### DELTA DENTAL PPO™-EPO PLAN DESIGN

- ❖ There are no out-of-network benefits under the Delta Dental PPO-EPO Plan. Therefore, you will be held responsible for all charges.

### DELTA DENTAL HIGH PLAN OR DELTA DENTAL LOW PLAN

- ❖ You will be responsible for paying the difference between the non-participating dentists' charges and Delta Dental's payment.
- ❖ Benefits may be lower when visiting a non-participating dentist.
- ❖ The dentist is not required to file the claim for you, and you may be required to pay the dentist at the time services are rendered and then file a claim for reimbursement from Delta Dental.

## 9. What do I need for my first dental appointment?

- ❖ Present your ID card or give the dentist your Subscriber Identification Number.
- ❖ Tell the dentist you are covered by Delta Dental of Virginia.
- ❖ Claim forms are typically filed directly by dental offices. Delta Dental will accept any standard ADA approved claim form. Forms are available online at [www.deltadentalva.com](http://www.deltadentalva.com) or by calling Delta Dental's toll-free number.

## 10. How does orthodontic coverage work for these plans?

### DELTA DENTAL PPO™-EPO PLAN DESIGN

- ❖ Treatment must be provided by an orthodontist in the Delta Dental PPO network. Delta Dental will pay 50% of the plan allowance up to the \$2,000 lifetime maximum for each eligible family member.

### DELTA DENTAL HIGH PLAN

- ❖ Treatment can be provided by any licensed dentist, but you will obtain maximum benefits if services are provided by a Delta Dental PPO or Delta Dental Premier orthodontist. Delta Dental will pay 50% of the plan allowance up to the \$1,000 lifetime maximum for each eligible family member. Orthodontia is not covered under the Low plan.

## 11. How will Delta Dental pay for orthodontia claims for individuals who are currently receiving orthodontia benefits from their previous dental carrier?

If you are a new subscriber in either the EPO Plan or the High plan, Delta Dental will calculate the amount the plan would normally pay, then deduct the amount already paid by the previous carrier, and complete the normal claim payment process for the duration of orthodontic treatment.

## Benefits for Hanover County & Schools

### High Plan

Group Number: 000006361

Effective Date: January 1, 2021

Annual Deductible ( <i>Applies to Basic and Major Services</i> )	\$50 per person; \$150 per family, per calendar year
Annual Maximum	\$1,500 per enrollee, per calendar year
Orthodontic Lifetime Maximum	\$1,000 per person
<b>Prevention First</b>	Visits to the dentist for Diagnostic and Preventive Services will not count against the Annual Maximum.
<b>Healthy Smile, Healthy You® Program</b>	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 <b>Healthy Smile, Healthy You Program</b> is simple. Visit <a href="http://DeltaDentalVA.com">DeltaDentalVA.com</a> 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	In-Network		Out-of-Network	Benefit Limitations	Benefit Waiting Period
	PPO	Premier			
<b>Diagnostic and Preventive Services</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>		<b>None</b>
<ul style="list-style-type: none"> <li>Oral exams and cleanings</li> <li>Fluoride applications</li> <li>Bitewing X-rays</li> <li>Full mouth/panelpipse X-rays</li> <li>Sealants</li> <li>Space maintainers</li> </ul>				<p>Twice in a calendar year. Periodontal cleaning is considered a regular cleaning and is subject to the benefit limits for regular cleanings.</p> <p>Twice in a calendar year for enrollees under the age of 19.</p> <p>Bitewing X-rays are limited to once in a calendar year limited to a maximum of 4 films or a set (7-8 films) of vertical bitewings.</p> <p>Once in a 5-year period.</p> <p>One application per tooth every 5 years for enrollees under the age of 16 on non-carious, non-restored 1<sup>st</sup> and 2<sup>nd</sup> permanent molars.</p> <p>Once per quadrant per arch for enrollees under the age of 14.</p>	
<b>Basic Services</b>	<b>80%</b>	<b>80%</b>	<b>80%</b>		<b>None</b>
<ul style="list-style-type: none"> <li>Amalgam (silver) and composite (white) fillings</li> <li>Stainless steel crowns</li> <li>Simple extractions</li> <li>Complex oral surgery</li> <li>Endodontic services/root canal therapy</li> <li>Periodontic services</li> <li>Denture repair and recementation of crowns, bridges and dentures</li> </ul>				<p>Once per surface in a 24-month period.</p> <p>Primary (baby) teeth for enrollees under the age of 14.</p> <p>Surgical extractions and other surgical procedures.</p> <p>Retreatment only after 24 months from initial root canal therapy treatment.</p> <p>Once per quadrant in a 24-36 month period based on services rendered.</p> <p>Once in a 12-month period after 6 months from initial placement.</p>	

Benefits continued on following page

## Benefits for Hanover County & Schools

### High Plan

**Group Number: 000006361**

**Effective Date: January 1, 2021**

Covered Benefits					
Delta Dental will pay the stated percentage of the plan allowance based on the dentist's participation with Delta Dental.					
Coverage	In-Network		Out-of-Network	Benefit Limitations	Benefit Waiting Period
	PPO	Premier			
<b>Major Services</b>	50%	50%	50%		6 months
<ul style="list-style-type: none"> <li>• Crowns</li> <li>• Prosthodontics, removable and fixed</li> <li>• Implants</li> </ul>				Once per tooth in a 7 year period for enrollees age 12 and older.  Once in a 7 year period for enrollees age 16 and older.  Once per site for enrollees age 16 and older.	
<b>Orthodontic Services</b>	50%	50%	50%		6 months
<ul style="list-style-type: none"> <li>• Treatment for the proper alignment of teeth</li> </ul>				For subscriber and covered dependents.	

*Employees hired after the initial enrollment may have the waiting period waived by providing proof of credible coverage.*

#### **COVERAGE IS AVAILABLE FOR**

- Enrollee, spouse
- Dependent children, only to the end of the Calendar Year 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 Virginia law requires otherwise.

Please visit [DeltaDentalVA.com](http://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
<b>Dentist's Charge for Covered Procedure</b>	<b>\$215.00</b>	<b>\$215.00</b>	<b>\$215.00</b>
<b>Delta Dental's Plan Allowance</b>	<b>\$126.00</b>	<b>\$169.00</b>	<b>\$113.00</b>
<b>Coinsurance Percentage</b>	<b>80%</b>	<b>80%</b>	<b>80%</b>
<b>Delta Dental's Payment</b>	<b>\$100.80</b>	<b>\$135.20</b>	<b>\$90.40</b>
<b>Patient Payment*</b>	<b>\$25.20</b>	<b>\$33.80</b>	<b>\$124.60</b>

*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.*



# Delta Dental PPO plus Premier™

## Benefits for Hanover County & Schools

### Low Plan

Group Number: 000006361

Effective Date: January 1, 2021

Annual Deductible <i>(Applies to Basic and Major Services)</i>	\$50 per person; \$150 per family, per calendar year
Annual Maximum	\$1,000 per enrollee, per calendar year
<b>Prevention First</b>	Visits to the dentist for Diagnostic and Preventive Services will not count against the Annual Maximum.
<b>Healthy Smile, Healthy You<sup>®</sup> Program</b>	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 <b>Healthy Smile, Healthy You Program</b> is simple. Visit <a href="http://DeltaDentalVA.com">DeltaDentalVA.com</a> 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	In-Network		Out-of-Network	Benefit Limitations	Benefit Waiting Period
	PPO	Premier			
<b>Diagnostic and Preventive Services</b>	100%	100%	100%		None
<ul style="list-style-type: none"> <li>Oral exams and cleanings</li> <li>Fluoride applications</li> <li>Bitewing X-rays</li> <li>Full mouth/panelpipse X-rays</li> <li>Sealants</li> <li>Space maintainers</li> </ul>				<p>Twice in a calendar year. Periodontal cleaning is considered a regular cleaning and is subject to the benefit limits for regular cleanings.</p> <p>Twice in a calendar year for enrollees under the age of 19.</p> <p>Bitewing X-rays are limited to once in a calendar year; limited to a maximum of 4 bitewing films in one visit or a set of (7-8) vertical bitewing films.</p> <p>Once in a 5-year period.</p> <p>One application per tooth every 5 years for enrollees under the age of 16 on non-carious, non-restored 1<sup>st</sup> and 2<sup>nd</sup> permanent molars.</p> <p>Once per quadrant per arch for enrollees under the age of 14.</p>	
<b>Basic Services</b>	80%	80%	80%		None
<ul style="list-style-type: none"> <li>Amalgam (silver) and composite (white) fillings</li> <li>Stainless steel crowns</li> <li>Simple extractions</li> <li>Complex oral surgery</li> <li>Endodontic services/root canal therapy</li> <li>Periodontic services</li> <li>Denture repair and recementation of crowns, bridges and dentures</li> </ul>				<p>Once per surface in a 24-month period.</p> <p>Primary (baby) teeth for enrollees under the age of 14.</p> <p>Surgical extractions and other surgical procedures.</p> <p>Retreatment only after 24 months from initial root canal therapy treatment.</p> <p>Once per quadrant in a 24-36 month period based on services rendered.</p> <p>Once in a 12-month period after 6 months from initial placement.</p>	

Benefits continued on following page

## Benefits for Hanover County & Schools

### Low Plan

Group Number: 000006361

Effective Date: January 1, 2021

#### COVERAGE IS AVAILABLE FOR

- Enrollee, spouse
- Dependent children, only to the end of the Calendar Year 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 Virginia law requires otherwise.

Please visit [DeltaDentalVA.com](http://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.*

## **Delta Dental High Plan and Low Plan Limitations & Exclusions**

### **LIMITATIONS**

The following limitations apply to all contracts and contain Dental Services that may not be a Covered Benefit under this plan. Please refer to the **Schedule of Benefits** in your plan documents for a list of Covered Benefits.

- Oral exams are limited to twice in a Calendar Year.
- Consultations and evaluations for deep sedation or general anesthesia are limited to twice in a Calendar Year and are subject to the benefit limitation for regular exams.
- Cleanings are limited to twice in a Calendar Year.
- Periodontal cleanings are limited to twice in a Calendar Year.
- Scaling in presence of generalized moderate or severe gingival inflammation is subject to the benefit limitation of a regular cleaning or periodontal maintenance.
- Full mouth debridement is a Covered Benefit when an Enrollee has not had a cleaning or scaling and root planing within 36 months of the full mouth debridement.
- Full mouth debridement is limited to once in a lifetime.
- Fluoride applications are limited to twice in a Calendar Year for Enrollees under the age of 19.
- Bitewing X-rays are limited to once in a Calendar Year; limited to a maximum of 4 bitewing films in one visit or a set of (7-8) vertical bitewing films.
- Full mouth/panoramic X-rays are limited to once in a 5 year period.
- Sealants and preventive resin restorations are limited to non-carious, non-restored 1st and 2nd permanent molars for Dependents under the age of 16, one application per tooth in a 5 year period.
- Amalgam (silver) and composite (white) fillings are limited to once per tooth per surface in a 24 month period.
- Space maintainers, not including distal shoe space maintainers, are limited to once per quadrant per arch per lifetime for Enrollees under the age of 14.
- Distal shoe space maintainers are limited to once per quadrant per arch per lifetime for Enrollees under the age of 9.
- Retreatment of root canal therapy is a Covered Benefit 2 years after initial root canal therapy and is limited to once in a lifetime.
- Replacement of an existing crown not related to an implant is a Covered Benefit once every 7 years per tooth and when the existing crown is not serviceable.
- Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is limited to once per tooth in a 24 month period.
- Recementation of existing crowns and inlays are limited to once in a 12 consecutive month period and only if performed more than six (6) months after the placement of the initial crown or inlay.
- Replacement of an existing prosthetic not related to an implant is a Covered Benefit once every 7 years and when the existing prosthesis is not serviceable.
- Denture adjustments are limited to twice in a 12 consecutive month period and only if performed more than six (6) months after the placement of the initial denture.
- Denture repair is limited to once in a 12 consecutive month period and only if performed more than six (6) months after the placement of the initial denture.
- Implants and implant supported prosthetics are limited to once in a life-time per site for Enrollees age 16 and older.
- Implants are limited to 2 per quadrant and 4 per each arch with a maximum of 8 for full mouth reconstruction.
- A full mouth X-ray includes bitewing X-rays; panoramic X-ray in conjunction with any other X-ray is considered a full mouth X-ray.
- Stainless steel crowns are limited to primary (baby) teeth for Enrollees under the age of 14.

- Gingivectomy or gingivoplasty is limited to once per quadrant in a 36 month period.
- Gingival flap procedures are limited to once per quadrant in a 36 month period.
- Osseous surgery is limited to once per quadrant in a 36 month period.
- Periodontal scaling and root planing is limited to once per quadrant in a 24 month period.
- Autogenous and non-autogenous connective tissue graft procedures; distal or proximal wedge procedure; combined connective tissue and double pedicle graft procedures are limited to once per site in a 36 month period.
- Fixed bridges or removable partials are limited to Enrollees age 16 and older.
- Crowns are a Covered Benefit when the tooth damaged by decay or fracture cannot be restored by amalgam or composite restoration.
- Crowns are limited to Enrollees age 12 and older.
- Temporary prosthetic devices are not a separate benefit. Any charge for these devices is included in the fee for the permanent device.
- Orthodontic services are limited to Enrollees age 5 and older.
- Bone harvesting is limited to once in a lifetime per tooth.
- Adjustment, maintenance or cleaning of a maxillofacial prosthetic appliance is limited to once per year.

## **EXCLUSIONS**

The following are not covered benefits under any circumstances **unless specifically identified** as a Covered Benefit in the plan documents.

- Services or supplies that are not dental services; also services not specifically listed as covered in the plan documents.
- Services or treatment provided by someone other than a licensed dentist or a qualified licensed dental hygienist working under the supervision of a dentist.
- A dental service that Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to you), determines is not necessary or customary for the diagnosis or treatment of your condition. In making this determination, Delta Dental will take into account generally accepted dental practice standards based on the dental services provided. In addition, each covered benefit must demonstrate dental necessity. Dental Necessity is determined in accordance with generally accepted standards of dentistry.
- Dental services for injuries or conditions that may be covered under workers compensation or similar employer liability laws or other medical plan coverage; also benefits or services that are available under any federal or state government program (subject to the rules and regulations of those programs) or from any charitable foundation or similar entity.
- Dental services for the diagnosis or treatment for illnesses, injuries or other conditions for which you are eligible for coverage under your hospital, medical/surgical, or major medical plan.
- Dental services started or rendered before the date enrolled under this dental plan. Also, except as otherwise provided in the plan documents, benefits for a course of treatment that began before enrolled under this dental plan.
- Except as otherwise provided in the plan documents, dental services provided after the date that the individual is no longer enrolled or eligible for coverage under the plan documents.
- Except as otherwise provided in the plan documents, prescription and non-prescription drugs; pre-medications; preventive control programs, oral hygiene instructions, and relative analgesia.
- General anesthesia when less than three (3) teeth will be routinely extracted during the same office visit.
- Splinting or devices used to support, protect, or immobilize oral structures that have loosened or been reimplanted, fractured or traumatized.
- Charges for inpatient or outpatient hospital services; any additional fee that the dentist may charge for treating a patient in a hospital, nursing home or similar facility.
- Charges to complete a claim form, copy records, or respond to Delta Dental's requests for information.
- Charges for failure to keep a scheduled appointment.

- Charges for consultations in person, by phone or by other electronic means.
- Charges for x-ray interpretation.
- Dental services to the extent that benefits are available or would have been available if you had been enrolled, applied for, or maintained eligibility under Title XVIII of the Social Security Act (Medicare), including any amendments or other changes to that Act.
- Complimentary services or dental services for which you would not be obligated to pay in the absence of the coverage under the plan documents or any similar coverage.
- Services or treatment provided to an immediate family member by the treating dentist. This would include a dentist's parent, spouse or child.
- Dental services and supplies for the replacement device or repeat treatment of lost, misplaced or stolen prosthetic devices including space maintainers, bridges and dentures (among other devices).
- Dental services or other services that Delta Dental determines are for correcting congenital malformations; also, cosmetic surgery or dentistry for cosmetic purposes.
- Replacement of congenitally missing teeth by dental implant, fixed or removable prosthesis whether the result of a medical diagnosis including but not limited to hereditary ectodermal dysplasia or not related to a medical diagnosis.
- Experimental or investigative dental procedures, services, supplies as well as services and/or procedures due to complications thereof. Experimental or investigative procedures, services or supplies are those which, in the judgment of the Delta Dental: (a) are in a trial stage; (b) are not in accordance with generally accepted standards of dental practice, or (c) have not yet been shown to be consistently effective for the diagnosis or treatment of the enrollee's condition.
- Dental services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include but are not limited to equilibration and periodontal splinting.
- Dental services, procedures and supplies that are needed because of harmful habits. An example of a harmful habit includes clenching or grinding of the teeth.
- Services billed under multiple dental service procedure codes that Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to you), determines should have been billed under a single, more comprehensive dental service procedure code. Delta Dental bases its payment on the plan allowance for the more comprehensive code, not on the plan allowance(s) for the underlying component codes.
- Services billed under a dental service procedure code that Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to you), determines should have been billed under a code that more accurately describes the dental service. Delta Dental bases its payment on its determination of the more accurate dental service code.
- Amounts assessed on dental services and/or supplies by state or local regulation.
- Amounts that exceed the plan allowance as agreed to by the dentist for covered benefits.

Benefits continued on following page

**Benefits for Hanover County & Schools**  
**EPO Plan**  
**Group Number: 000006361**  
**Effective Date: January 1, 2021**

<b>Annual Deductible</b>	<b>None</b>
<b>Annual Maximum</b>	<b>\$2,000</b> per enrollee, per calendar year
<b>Orthodontic Lifetime Maximum</b>	<b>\$2,000</b> per person
<b>Healthy Smile, Healthy You® Program</b>	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 <b>Healthy Smile, Healthy You Program</b> is simple. Visit <a href="http://DeltaDentalVA.com">DeltaDentalVA.com</a> to print an enrollment form.

\*Emergency services are covered benefits that require immediate attention to alleviate severe pain, swelling or bleeding or to avoid serious jeopardy to your health. Your benefit for all emergency services that non-participating dentists provide is limited to a maximum of \$50 per calendar year.

**Covered Benefits**

Delta Dental will pay the Delta Dental PPO plan allowance less the patient copayment amount listed on the **Schedule of Benefits and Copayments/Coinsurance**. The patient will be responsible for the copayment listed on the **Schedule of Benefits and Copayments/Coinsurance**, plus any amounts over the Benefit Maximum.

<b>Coverage</b>	<b>In-Network Delta Dental PPO</b>	<b>Benefit Limitations</b>	<b>Benefit Waiting Period</b>
<b>Diagnostic and Preventive Services</b>	<b>Fixed Copayment</b>		<b>None</b>
<ul style="list-style-type: none"> <li>• Oral exams and cleanings</li> <li>• Fluoride applications</li> <li>• Bitewing X-rays</li> <li>• Full mouth/panelpipe X-rays</li> <li>• Sealants</li> <li>• Space maintainers</li> </ul>		Twice in a calendar year. Periodontal cleaning is considered a regular cleaning and is subject to the benefit limits for regular cleanings. Once in a calendar year for enrollees under the age of 19. Bitewing X-rays are limited to once in a calendar year; limited to a maximum of 4 bitewing films in one visit or a set of (7-8) vertical bitewing films. Once in a 3-year period. One application per tooth for enrollees under the age of 16 on non-carious, non-restored 1 <sup>st</sup> and 2 <sup>nd</sup> permanent molars. Once per quadrant per arch for enrollees under the age of 14.	
<b>Basic Services</b>	<b>Fixed Copayment</b>		<b>None</b>
<ul style="list-style-type: none"> <li>• Amalgam (silver) and composite (white) fillings</li> <li>• Stainless steel crowns</li> <li>• Simple extractions</li> <li>• Endodontic services/root canal therapy</li> <li>• Periodontic services</li> <li>• Complex Oral surgery</li> <li>• Denture repair and recementation of crowns, bridges and dentures</li> </ul>		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.	
<b>Major Services</b>	<b>Fixed Copayment</b>		<b>None</b>
<ul style="list-style-type: none"> <li>• Crowns</li> <li>• Prosthodontics, removable and fixed</li> <li>• Implants</li> </ul>		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.	

## Benefits for Hanover County & Schools

### EPO Plan

**Group Number: 000006361**

**Effective Date: January 1, 2021**

<b>Covered Benefits</b>			
Delta Dental will pay the stated percentage of the Delta Dental PPO plan allowance up to the Benefit Maximum. The patient will be responsible for their share of the coinsurance, plus any amounts over the Benefit Maximum.			
Coverage	In-Network Delta Dental PPO	Benefit Limitations	Benefit Waiting Period
<b>Orthodontic Services</b>	<b>50%</b>		<b>None</b>
<ul style="list-style-type: none"> <li>• Treatment for the proper alignment of teeth</li> </ul>		For subscriber and covered dependents.	

#### **COVERAGE IS AVAILABLE FOR**

- Enrollee, spouse
- Dependent children, only to the end of the Calendar Year they reach age 26 (the “limiting age”).

#### **CHOOSING A DENTIST**

A Delta Dental PPO dentist must provide covered benefits. In almost all cases, services rendered by a dentist that is not in the Delta Dental PPO network are not covered. There is one exception. You may receive covered benefits from a dentist that is not in the Delta Dental PPO network if the covered benefit(s) are emergency services and you are at least 35 miles from a Delta Dental PPO dentist’s office. However, your benefit maximum for all emergency services provided by a dentist that is not in the Delta Dental PPO network is limited to \$50 per benefit period. **Emergency services** are covered benefits that require immediate attention to alleviate severe pain, swelling, bleeding or to avoid serious jeopardy to your health.

Delta Dental PPO dentists have agreed to accept the Delta Dental PPO plan allowance. Delta Dental PPO dentists will submit claims directly to Delta Dental and we will issue the payment to the dentist.

You are responsible for the dentist fee(s) when you receive dental services from a dentist who does not participate in the Delta Dental PPO network; unless, they are emergency services and a Delta Dental PPO dentist is at least 35 miles away.

Please visit [DeltaDentalVA.com](http://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
<b>Dentist’s Charge for Covered Procedure</b>	<b>\$215.00</b>	<b>\$215.00</b>	<b>\$215.00</b>
<b>Delta Dental’s Plan Allowance</b>	<b>\$126.00</b>	<b>\$.00</b>	<b>\$.00</b>
<b>Patient Copayment</b>	<b>\$25.00</b>	<b>\$.00</b>	<b>\$.00</b>
<b>Delta Dental’s Payment</b>	<b>\$101.00</b>	<b>\$.00</b>	<b>\$.00</b>
<b>Patient Payment*</b>	<b>\$25.00</b>	<b>\$215.00</b>	<b>\$215.00</b>
<b>Amount Dentist Receives</b>	<b>\$126.00</b>	<b>\$215.00</b>	<b>\$215.00</b>

*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.*



## DELTA DENTAL PPO™ – EPO PLAN DESIGN – HANOVER COUNTY & SCHOOLS

### SCHEDULE OF BENEFITS AND COPAYMENT/COPAYMENT

The benefits shown below are performed as deemed appropriate by the attending Dentist subject to the limitations and exclusions of the program. Please refer to the Limitations and Exclusions for further clarification of benefits. Enrollees should discuss all treatment options with their Dentist prior to services being rendered.

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the plan and are not to be interpreted as CDT procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association (ADA). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

<u>CODES</u>	<u>COPAYMENT/ COINSURANCE</u>
<i>I. DIAGNOSTIC</i>	
D0120 Periodic oral evaluation-established patient	No Cost
D0140 Limited oral evaluation—problem focused	No Cost (GP)
D0140 Limited oral evaluation—problem focused	\$30.00 (SP)
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150 Comprehensive oral evaluation – new or established patient	No Cost (GP)
D0150 Comprehensive oral evaluation – new or established patient	\$30.00 (SP)
D0160 Detailed and extensive oral evaluation—problem focused, by report	No Cost (GP)
D0160 Detailed and extensive oral evaluation—problem focused, by report	\$30.00 (SP)
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0180 Comprehensive periodontal evaluation – new or established patient	No Cost (GP)
D0180 Comprehensive periodontal evaluation – new or established patient	\$30.00 (SP)
D0210 Intraoral - complete series of radiographic images	No Cost
D0220 Intraoral - periapical first radiographic image	No Cost
D0230 Intraoral - periapical each additional radiographic image	No Cost
D0240 Intraoral - occlusal radiographic image	No Cost
D0270 Bitewing - single radiographic image	No Cost
D0272 Bitewings - two radiographic images	No Cost
D0273 Bitewings - three radiographic images	No Cost
D0274 Bitewings - four radiographic	No Cost
D0277 Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330 Panoramic radiographic image	No Cost
D0460 Pulp vitality tests	No Cost
D0470 Diagnostic casts	No Cost

GP – General Practitioner  
SP - Specialty Practitioner

<i>II. PREVENTIVE</i>	
D1110 Prophylaxis <i>cleaning</i> – adult	No Cost
D1120 Prophylaxis <i>cleaning</i> – child	No Cost
D1206 Topical application of fluoride varnish	No Cost
D1208 Topical application of fluoride excluding varnish	No Cost
D1330 Oral hygiene instructions	No Cost

CODESCOPAYMENT/  
COINSURANCE

D1351	Sealant - per tooth	\$12.00
D1352	Preventive resin restoration in a moderate to high caries risk patient	\$12.00
D1510	Space maintainer - fixed, unilateral - per quadrant	\$66.00
D1516	Space maintainer - fixed - bilateral, maxillary	\$66.00
D1517	Space maintainer - fixed - bilateral, mandibular	\$66.00
D1520	Space maintainer - removable, unilateral - per quadrant	\$66.00
D1526	Space maintainer - removable - bilateral, maxillary	\$66.00
D1527	Space maintainer - removable - bilateral, mandibular	\$66.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	\$12.00
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	\$12.00
D1553	Re-cement or re-bond unilateral space maintainer- per quadrant	\$12.00
D1556	Removal of fixed unilateral space maintainer - per quadrant	\$12.00
D1557	Removal of fixed bilateral space maintainer - maxillary	\$12.00
D1558	Removal of fixed bilateral space maintainer - mandibular	\$12.00
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	\$66.00

*III. RESTORATIVE (Fillings)**Includes indirect pulp capping, bases, liners and acid etch procedures*

D2140	Amalgam - one surface, primary or permanent	\$24.00
D2150	Amalgam - two surfaces, primary or permanent	\$26.00
D2160	Amalgam - three surfaces, primary or permanent	\$29.00
D2161	Amalgam - four or more surfaces, primary or permanent	\$31.00
D2330	Resin-based composite - one surface, anterior	\$25.00
D2331	Resin-based composite - two surfaces, anterior	\$31.00
D2332	Resin-based composite - three surfaces, anterior	\$36.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	\$42.00
D2390	Resin-based composite crown, anterior	\$66.00
D2391	Resin-based composite - one surface, posterior	Optional
D2392	Resin-based composite - two surfaces, posterior	Optional
D2393	Resin-based composite - three surfaces, posterior	Optional
D2394	Resin-based composite - four or more surfaces, posterior	Optional
D2410	Gold foil - one surface	Optional
D2420	Gold foil - two surfaces	Optional
D2430	Gold foil - three surfaces	Optional
D2510	Inlay - metallic - one surface	\$340.00
D2520	Inlay - metallic - two surfaces	\$340.00
D2530	Inlay - metallic - three or more surfaces	\$340.00
D2542	Onlay - metallic - two surfaces	\$395.00
D2543	Onlay - metallic - three surfaces	\$395.00
D2544	Onlay - metallic - four or more surfaces	\$395.00
D2610	Inlay - porcelain/ceramic - one surface	Optional
D2620	Inlay - porcelain/ceramic - two surfaces	Optional
D2630	Inlay - porcelain/ceramic - three or more surfaces	Optional
D2642	Onlay - porcelain/ceramic - two surfaces	Optional
D2643	Onlay - porcelain/ceramic - three surfaces	Optional
D2644	Onlay - porcelain/ceramic - four or more surfaces	Optional
D2650	Inlay - resin-based composite - one surface	Optional
D2651	Inlay - resin-based composite - two surfaces	Optional
D2652	Inlay - resin-based composite - three or more surfaces	Optional
D2662	Onlay - resin-based composite - two surfaces	Optional
D2663	Onlay - resin-based composite - three surfaces	Optional
D2664	Onlay - resin-based composite - four or more surfaces	Optional
D2710	Crown - resin-based composite (indirect)	\$195.00
D2720	Crown - resin with high noble metal	\$365.00
D2721	Crown - resin with predominately base metal	\$345.00
D2722	Crown - resin with noble metal	\$365.00
D2740	Crown - porcelain/ceramic	\$425.00
D2750	Crown - porcelain fused to high noble metal	\$385.00

CODESCOPAYMENT/  
COINSURANCE

D2751	Crown - porcelain fused to predominately base metal	\$345.00
D2752	Crown - porcelain fused to noble metal	\$365.00
D2753	Crown - porcelain fused to titanium and titanium alloys	\$425.00
D2780	Crown - ¾ cast high noble metal	\$385.00
D2781	Crown - ¾ cast predominately base metal	\$345.00
D2782	Crown - ¾ cast noble metal	\$365.00
D2783	Crown - ¾ cast porcelain/ceramic	\$425.00
D2790	Crown - full cast high noble metal	\$385.00
D2791	Crown - full cast predominately base metal	\$345.00
D2792	Crown - full cast noble metal	\$365.00
D2794	Crown - titanium and titanium alloys	\$425.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$12.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	\$12.00
D2920	Re-cement or re-bond crown	\$12.00
D2930	Prefabricated stainless steel crown - primary tooth	\$66.00
D2931	Prefabricated stainless steel crown - permanent tooth	\$66.00
D2932	Prefabricated resin crown - <i>anterior primary tooth</i>	\$66.00
D2933	Prefabricated stainless steel crown with resin window - <i>anterior primary tooth</i>	Optional
D2940	Protective restoration	\$19.00
D2950	Core buildup, including any pins when required	\$24.00
D2951	Pin retention - per tooth, in addition to restoration	\$24.00
D2952	Post and core in addition to crown, indirectly fabricated	\$24.00
D2953	Each additional indirectly fabricated post - same tooth	\$24.00
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	\$24.00
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	\$24.00
D2971	Additional procedures to construct new crown under existing partial denture framework	\$55.00
D2980	Crown repair necessitated by restorative material failure	\$72.00

IV. *ENDODONTICS*

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$19.00
D3221	Pulpal debridement, primary and permanent teeth	\$18.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$19.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	\$19.00
D3310	<i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration)	\$72.00
D3320	<i>Root canal</i> - endodontic therapy, premolar tooth (excluding final restoration)	\$144.00
D3330	<i>Root canal</i> - endodontic therapy, molar tooth (excluding final restoration)	\$216.00
D3346	Retreatment of previous root canal therapy - anterior	\$87.00
D3347	Retreatment of previous root canal therapy - premolar	\$172.00
D3348	Retreatment of previous root canal therapy - molar	\$260.00
D3410	Apicoectomy - anterior	\$120.00
D3421	Apicoectomy - premolar (first root)	\$120.00
D3425	Apicoectomy - molar (first root)	\$120.00
D3426	Apicoectomy (each additional root)	\$60.00
D3430	Retrograde filling - per root	\$60.00

V. *PERIODONTICS*

*Includes preoperative and postoperative evaluations and treatment under a local anesthetic*

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	\$210.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	\$210.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure per tooth	\$210.00

<u>CODES</u>		<u>COPAYMENT/ COINSURANCE</u>
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces, per quadrant	\$180.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces, per quadrant	\$180.00
D4245	Apically positioned flap	\$180.00
D4249	Clinical crown lengthening - hard tissue	\$175.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$360.00
D4261	Osseous surgery (including elevation of full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$360.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	\$54.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	\$54.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis on subsequent visit	\$54.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	No Cost
D4910	Periodontal maintenance	\$44.00
VI.	<i>PROSTHODONTICS, (removable)</i>	
D5110	Complete denture - maxillary	\$460.00
D5120	Complete denture - mandibular	\$460.00
D5130	Immediate denture - maxillary	\$460.00
D5140	Immediate denture - mandibular	\$460.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$410.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$410.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$530.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$530.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	\$410.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	\$410.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$530.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$530.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	Optional
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	Optional
D5282	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	\$420.00
D5283	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular	\$420.00
D5284	Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant	\$420.00
D5286	Removable unilateral partial denture - one piece resin (including clasps and teeth) - per quadrant	\$420.00
D5410	Adjust complete denture - maxillary	\$12.00
D5411	Adjust complete denture - mandibular	\$12.00
D5421	Adjust partial denture - maxillary	\$12.00
D5422	Adjust partial denture - mandibular	\$12.00
D5511	Repair broken complete denture base, mandibular	\$30.00
D5512	Repair broken complete denture base, maxillary	\$30.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$12.00
D5611	Repair resin partial denture base, mandibular	\$30.00
D5612	Repair resin partial denture base, maxillary	\$30.00

CODESCOPAYMENT/  
COINSURANCE

D5621	Repair cast partial framework, mandibular	\$30.00
D5622	Repair cast partial framework, maxillary	\$30.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	\$30.00
D5640	Replace broken teeth - per tooth	\$12.00
D5650	Add tooth to existing partial denture	\$12.00
D5660	Add clasp to existing partial denture - per tooth	\$12.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$185.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$185.00
D5710	Rebase complete maxillary denture	\$60.00
D5711	Rebase complete mandibular denture	\$60.00
D5720	Rebase maxillary partial denture	\$60.00
D5721	Rebase mandibular partial denture	\$60.00
D5730	Reline complete maxillary denture (chairside)	\$36.00
D5731	Reline complete mandibular denture (chairside)	\$36.00
D5740	Reline maxillary partial denture (chairside)	\$36.00
D5741	Reline mandibular partial denture (chairside)	\$36.00
D5750	Reline complete maxillary denture (laboratory)	\$60.00
D5751	Reline complete mandibular denture (laboratory)	\$60.00
D5760	Reline maxillary partial denture (laboratory)	\$60.00
D5761	Reline mandibular partial denture (laboratory)	\$60.00
D5820	Interim partial denture (maxillary)	\$30.00
D5821	Interim partial denture (mandibular)	\$30.00
D5850	Tissue conditioning, maxillary	\$30.00
D5851	Tissue conditioning, mandibular	\$30.00
D5863	Overdenture - complete maxillary	Optional
D5864	Overdenture - partial maxillary	Optional
D5865	Overdenture - complete mandibular	Optional
D5866	Overdenture - partial mandibular	Optional

VII. *MAXILLOFACIAL PROSTHETICS - NOT COVERED (D5900-D5999)*VIII. *IMPLANT SERVICES - NOT COVERED (D6000-D6199)*IX. *PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in fixed partial denture [bridge])*

D6210	Pontic - cast high noble metal	\$385.00
D6211	Pontic - cast predominantly base metal	\$340.00
D6212	Pontic - cast noble metal	\$365.00
D6240	Pontic - porcelain fused to high noble metal	\$385.00
D6241	Pontic - porcelain fused to predominantly base metal	\$340.00
D6242	Pontic - porcelain fused to noble metal	\$365.00
D6250	Pontic - resin with high noble metal	\$385.00
D6251	Pontic - resin with predominantly base metal	\$340.00
D6252	Pontic - resin with noble metal	\$365.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis	Optional
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Optional
D6600	Retainer inlay - porcelain/ceramic, two surfaces	Optional
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	Optional
D6602	Retainer inlay - cast high noble metal, two surfaces	\$210.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	\$210.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	\$190.00
D6605	Retainer inlay - cast predominately base metal, three or more surfaces	\$340.00
D6606	Retainer inlay - cast noble metal, two surfaces	\$365.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	\$365.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	Optional
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	Optional
D6610	Retainer onlay - cast high noble metal, two surfaces	\$385.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	\$385.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	\$340.00

CODESCOPAYMENT/  
COINSURANCE

D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	\$340.00
D6614	Retainer onlay - cast noble metal, two surfaces	\$365.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	\$365.00
D6720	Retainer crown - resin with high noble metal	\$385.00
D6721	Retainer crown - resin with predominantly base metal	\$340.00
D6722	Retainer crown - resin with noble metal	\$365.00
D6750	Retainer crown - porcelain fused to high noble metal	\$385.00
D6751	Retainer crown - porcelain fused to predominantly base metal	\$340.00
D6752	Retainer crown - porcelain fused to noble metal	\$365.00
D6780	Retainer crown - ¾ cast high noble metal	\$385.00
D6781	Retainer crown - ¾ cast predominantly base metal	\$340.00
D6782	Retainer crown - ¾ cast noble metal	\$365.00
D6790	Retainer crown - full cast high noble metal	\$385.00
D6791	Retainer crown - full cast predominantly base metal	\$340.00
D6792	Retainer crown - full cast noble metal	\$365.00
D6930	Re-cement or re-bond fixed partial denture	\$18.00
D6940	Stress breaker	\$42.00

X. *ORAL AND MAXILLOFACIAL SURGERY*

*Includes preoperative and postoperative evaluations and treatment under a local anesthetic*

D7111	Extraction, coronal remnants - primary teeth	\$22.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$22.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$36.00
D7220	Removal of impacted tooth - soft tissue	\$60.00
D7230	Removal of impacted tooth - partially bony	\$90.00
D7240	Removal of impacted tooth - completely bony	\$120.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$120.00
D7250	Removal of residual tooth roots (cutting procedure)	\$42.00
D7286	Incisional biopsy of oral tissue - soft	\$30.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$78.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$78.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$102.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$102.00
D7471	Removal of lateral exostosis (maxilla or mandible)	\$78.00
D7472	Removal of torus palatinus	\$78.00
D7473	Removal of torus mandibularis	\$78.00
D7510	Incision and drainage of abscess - intraoral soft tissue	\$25.00
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	\$60.00

XI. *ORTHODONTICS*

Your Coinsurance is 50% of the Delta Dental PPO™ Dentist's Plan Allowance plus any amounts over the lifetime Benefit Maximum.

D0340	2D Cephalometric radiographic image - acquisition, measurement and analysis	50%
D0350	2D oral/facial photographic images obtained intraorally or extraorally	50%
D0470	Diagnostic casts	50%
D7280	Exposure of unerupted tooth	50%
D7283	Placement of device to facilitate eruption of impacted tooth	50%

CODESCOPAYMENT/  
COINSURANCE

D8010	Limited orthodontic treatment of the primary dentition	50%
D8020	Limited orthodontic treatment of the transitional dentition	50%
D8030	Limited orthodontic treatment of the adolescent dentition	50%
D8040	Limited orthodontic treatment of the adult dentition	50%
D8050	Interceptive orthodontic treatment of the primary dentition	50%
D8060	Interceptive orthodontic treatment of the transitional dentition	50%
D8070	Comprehensive orthodontic treatment of the transitional dentition	50%
D8080	Comprehensive orthodontic treatment of the adolescent dentition	50%
D8090	Comprehensive orthodontic treatment of the adult dentition	50%
D8210	Removable appliance therapy	50%
D8220	Fixed appliance therapy	50%
D8660	Pre-orthodontic treatment examination to monitor growth and development	50%
D8670	Periodic orthodontic treatment visit	50%
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	50%
D8698	Re-cement or re-bond fixed retainer – maxillary	50%
D8699	Re-cement or re-bond fixed retainer – mandibular	50%
D8701	Repair of fixed retainer, includes reattachment - maxillary	No Cost
D8702	Repair of fixed retainer, includes reattachment - mandibular	No Cost
XII.	<i>ADJUNCTIVE GENERAL SERVICES</i>	
D9110	Palliative (emergency) treatment of dental pain-minor procedure	\$18.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9310	Consultation - diagnostic services provided by a dentist or physician other than requesting dentist or physician	\$30.00
D9311	Consultation with a medical health care professional	No Cost
D9440	Office visit - after regularly scheduled hours	\$24.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9986	Missed appointment – <i>without 24 hour notice – per 15 minutes of appointment time</i>	\$10.00
D9987	Canceled appointment – <i>without 24 hour notice per 15 minutes of appointment time</i>	\$10.00
D9991	Dental case management – addressing appointment compliance barriers	No Cost
D9992	Dental case management – care coordination	No Cost
D9993	Dental case management – motivational interviewing	No Cost
D9994	Dental case management – patient education to improve oral health literacy	No Cost
D9995	Teledentistry – synchronous; real-time encounter	No Cost
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	No Cost
D9997	Dental case management – patients with special health care needs	No Cost

# Delta Dental PPO™-EPO Plan Design

## Limitations & Exclusions

### LIMITATIONS

Please refer to the Schedule of Benefits and Copayments/Coinsurance for a complete listing of Covered Benefits.

- Oral exams are limited to twice in a Calendar Year.
- Consultations and evaluations for deep sedation or general anesthesia are limited to twice in a Calendar Year. and are subject to the benefit limitation for regular exams.
- Regular or periodontal cleanings are limited to four times per Calendar Year, maximum of 2 regular cleanings.
- Scaling in presence of generalized moderate or severe gingival inflammation is subject to the benefit limitation of a regular cleaning or periodontal maintenance.
- Full mouth debridement is a Covered Benefit when an Enrollee has not had a cleaning or scaling and root planing within 36 months of the full mouth debridement.
- Full mouth debridement is limited to once in a lifetime.
- Fluoride applications are limited to once in a Calendar Year for Enrollees under the age of 19.
- Bitewing X-rays are limited to once in a Calendar Year; limited to a maximum of 4 bitewing films in one visit or a set of (7-8) vertical bitewing films.
- Full mouth/panelipse X-rays are limited to once in a 3 year period.
- Sealants and preventive resin restorations are limited to non-carious, non-restored 1st and 2nd permanent molars for Enrollees under the age of 16, one application per tooth.
- Amalgam (silver) and composite (white) fillings are limited to once per tooth per surface in a 24 month period.
- Space maintainers, not including distal shoe space maintainers, are limited to once per quadrant per arch per lifetime for Enrollees under the age of 14.
- Distal shoe space maintainers are limited to once per quadrant per arch per lifetime for Enrollees under the age of 9.
- Retreatment of root canal therapy is a Covered Benefit 2 years after initial root canal therapy and is limited to once in a lifetime.
- Replacement of an existing crown not related to an implant is a Covered Benefit once every 5 years per tooth and when the existing crown is not serviceable.
- Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is limited to once per tooth in a 24 month period.
- Recementation of existing crowns and inlays are limited to once in a 12 consecutive month period.
- Replacement of an existing prosthetic not related to an implant is a Covered Benefit once every 5 years and when the existing prosthesis is not serviceable.
- Denture adjustments are limited to twice in a 12 consecutive month period.
- Denture repair is limited to once in a 12 consecutive month period.
- Implants and implant supported prosthetics are limited to once in a life-time per site for Enrollees age 16 and older.
- Implants are limited to 2 per quadrant and 4 per each arch with a maximum of 8 for full mouth reconstruction.
- A full mouth X-ray includes bitewing X-rays; panoramic X-ray in conjunction with any other X-ray is considered a full mouth X-ray.
- Stainless steel crowns are limited to primary (baby) teeth for Enrollees under the age of 14.
- Gingivectomy or gingivoplasty is limited to once per quadrant in a 36 month period.
- Gingival flap procedures are limited to once per quadrant in a 36 month period.
- Osseous surgery is limited to once per quadrant in a 36 month period.

- Periodontal scaling and root planing is limited to once per quadrant in a 24 month period.
- Autogenous and non-autogenous connective tissue graft procedures; distal or proximal wedge procedure; combined connective tissue and double pedicle graft procedures are limited to once per site in a 36 month period.
- Fixed bridges or removable partials are limited to Enrollees age 16 and older.
- Crowns are a Covered Benefit when the tooth damaged by decay or fracture cannot be restored by amalgam or composite restoration.
- Crowns are limited to Enrollees age 12 and older.
- Temporary prosthetic devices are not a separate benefit. Any charge for these devices is included in the fee for the permanent device.
- Orthodontic services are limited to Enrollees age 5 and older.
- Bone harvesting is limited to once in a lifetime per tooth.
- Adjustment, maintenance or cleaning of a maxillofacial prosthetic appliance is limited to once per year.
- For inlay restorations, an alternate benefit will be allowed for the corresponding [amalgam (silver) filling/composite (white) filling]. Please refer Optional Treatment.
- For overdentures, an alternate benefit will be allowed for a conventional denture. Please refer to Optional Treatment.

## **EXCLUSIONS**

The following are not Covered Benefits **unless specifically identified** as a Covered Benefit in the **Schedule of Benefits and Copayment/Coinsurance**:

- Services or supplies that are not Dental Services; also services not specifically listed as covered in the **Schedule of Benefits and Copayment/Coinsurance**.
- Services or treatment provided by someone other than a licensed Dentist or a qualified licensed dental hygienist working under the supervision of a Dentist.
- A Dental Service that Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to you), determines is not necessary or customary for the diagnosis or treatment of your condition. In making this determination, Delta Dental will take into account generally accepted dental practice standards based on the Dental Services provided. In addition, each Covered Benefit must demonstrate Dental Necessity. Dental Necessity is determined in accordance with generally accepted standards of dentistry.
- Dental Services for injuries or conditions that may be covered under workers compensation, similar employer liability laws or other medical plan coverage; also benefits or services that are available under any federal or state government program (subject to the rules and regulations of those programs) or from any charitable foundation or similar entity.
- Dental Services for the diagnosis or treatment for illnesses, injuries or other conditions you are eligible for coverage under your hospital, medical/surgical, or major medical plan.
- Dental Services started or rendered before the date enrolled under this EOC. Also, except as otherwise provided in this EOC, benefits for a course of treatment that began before you are enrolled under this EOC.
- Except as otherwise provided for in this EOC, Dental Services provided after the date you are no longer enrolled or eligible for coverage under this EOC.
- Except as otherwise provided for in this EOC, prescription and non-prescription drugs; pre-medications; preventive control programs, oral hygiene instructions, and relative analgesia.
- General anesthesia when less than three (3) teeth will be routinely extracted during the same office visit.
- Splinting or devices used to support, protect, or immobilize oral structures that have loosened or been reimplanted, fractured or traumatized.
- Charges for inpatient or outpatient hospital services; any additional fee that the Dentist may charge for treating a patient in a hospital, nursing home or similar facility.
- Charges to complete a claim form, copy records, or respond to Delta Dental's requests for information.

- Charges for failure to keep a scheduled appointment.
- Charges for consultations in person, by phone or by other electronic means.
- Charges for x-ray interpretation.
- Dental Services to the extent that benefits are available or would have been available if you had enrolled, applied for, or maintained eligibility under Title XVIII of the Social Security Act (Medicare), including any amendments or other changes to that Act.
- Complimentary services or Dental Services for which you would not be obligated to pay in the absence of the coverage under this EOC or any similar coverage.
- Services or treatment provided to an immediate family member by the treating Dentist. This would include a Dentist's parent, spouse or child.
- Dental Services and supplies for the replacement device or repeat treatment of lost, misplaced or stolen prosthetic devices including space maintainers, bridges and dentures (among other devices).
- Dental Services or other services that Delta Dental determines are for correcting congenital malformations; also, cosmetic surgery or dentistry for cosmetic purposes.
- Replacement of congenitally missing teeth by dental implant, fixed or removable prosthesis whether the result of a medical diagnosis including but not limited to hereditary ectodermal dysplasia or not related to a medical diagnosis.
- Experimental or investigative dental procedures, services, supplies as well as services and/or procedures due to complications thereof. Experimental or investigative procedures, services or supplies are those which, in the judgment of the Delta Dental: (a) are in a trial stage; (b) are not in accordance with generally accepted standards of dental practice, or (c) have not yet been shown to be consistently effective for the diagnosis or treatment of the Enrollee's condition.
- Dental Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include but are not limited to equilibration and periodontal splinting.
- Except as otherwise provided for in this EOC, Dental Services, procedures and supplies needed because of harmful habits. An example of a harmful habit includes clenching or grinding of the teeth.
- Services billed under multiple Dental Service procedure codes which Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to you), determines should have been billed under a single, more comprehensive Dental Service procedure code. Delta Dental bases its payment on the Plan Allowance for the more comprehensive code, not on the Plan Allowance for the underlying component codes.
- Services billed under a Dental Service procedure code that Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to you), determines should have been billed under a code that more accurately describes the Dental Service. Delta Dental bases its payment on its determination of the more accurate Dental Service code.
- Amounts assessed on dental services and/or supplies by state or local regulation.
- Amounts that exceed the Plan Allowance as agreed to by the Dentist for Covered Benefits.

## INSTRUCTIONS FOR ENROLLING

1. **Review the Program Comparison and benefit summaries** to determine the plan best suited for your individual or family needs.
2. **Complete** the following information on the enclosed enrollment form. **PLEASE PRINT**
  - Social security number
  - Name
  - Address
  - Date of birth
  - Date of hire
  - Marital status
  - Type of plan
  - Type of coverage
  - Dependent information, if applicable
  - a) If you have chosen the **High Plan**:
    - ⇒ Check the “**Delta Dental PPO plus Premier™ High Plan**” box under “**Product**”
  - b) If you have chosen the **Low Plan**:
    - ⇒ Check the “**Delta Dental PPO plus Premier™ Low Plan**” box under “**Product**”
  - c) If you have chosen the **EPO Plan**:
    - ⇒ Check the “**Delta Dental PPO™- EPO Plan Design**” box under “**Product**”
3. **Sign** and **date** the enrollment form and return to your Human Resources office.

If you have any questions, please call your Human Resources office.