Henrico County
General Government

DELTA DENTAL

HCPS
HENRICO COUNTY PUBLIC SCHOOLS
The right to achieve.
The support to succeed.

Henrico County General Government and Public Schools 2017 Dental Plans

DeltaCare (DHMO) program

Under this program, you select a DeltaCare (DHMO) panel dentist for your dental care. Delta Dental of Virginia (Delta Dental) has contracted with a network of private dental offices. As an enrollee in the DeltaCare (DHMO) program you will select a dentist from the DeltaCare (DHMO) panel dentist listing for your family.

To use the DeltaCare (DHMO) program, just call your selected DeltaCare (DHMO) dentist to make an appointment.

Dental services which are not performed by your panel dentist or pre-authorized by Delta Dental will not be covered by the DeltaCare program.

Advantages of the DeltaCare (DHMO) program include:

- No claim forms to complete in most cases
- No deductibles to pay
- No annual maximum
- You know the exact cost prior to treatment
- $0 copayment on cleaning, exams and x-rays if they are performed by a General Practitioner (GP)

The DeltaCare (DHMO) program provides all reasonable and customary dental care if rendered by your DeltaCare (DHMO) panel dentist. There is no cost for covered services except for copayments on certain procedures. (See attached Description of Benefits and Copayments).

Delta Dental High and Low Option plans

The High and Low Option plans 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. 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** 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 payment allowance used by the Delta Dental in the state in which the dental service is provided.

If you visit a **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 plan 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.

Advantages of the Delta Dental High and Low Option plans include:
- go to any dentist you wish
- change dentists at any time
- go to a specialist of your choice without pre-approval

Henrico County General Government and Public Schools

Summary of Plan Benefits

Effective January 1, 2017

Plan Features for High and Low Option Plans	Delta Dental High and Low Option plans						DeltaCare Program
	High Option			Low Option			
	PPO Network	Premier Network	Out-of-Network	PPO Network	Premier Network	Out-of-Network	
DIAGNOSTIC & PREVENTIVE CARE/ PREVENTION FIRST ***These services are exempt from deductible and calendar year maximum.*** – Oral exams & cleanings - 2/calendar yr – Periodontal cleanings- 2/calendar yr – Fluoride treatment - 2/calendar yr (under age 19) – Bitewing x-rays - 2/calendar yr – Full mouth/panelipse x-rays - 1/ 5years – Space maintainers - dependents under age 14 – Sealants - only non-carious, non-restored 1st & 2nd permanent molars (under age 16; limited to one application per tooth every 3 years) – Healthy Smile, Healthy You ™–Enrolled pregnant members and/or enrolled diabetic members are entitled to an additional cleaning or periodontal maintenance visit	100%	100%	80%	75%	75%	75%	Refer to the attached **Schedule A-Description of Benefits, Copayments and DeltaCare Program Limitations and Exclusions** for specific covered services and copayments.
BASIC DENTAL CARE – Restorative - amalgam (silver) fillings; composite (white) fillings – Stainless steel crowns - baby/primary teeth only for dependents under age 14 – Oral surgery - simple extractions, impactions & other minor surgical procedures – Endodontics (root canal therapy) - repeat treatment covered only after 2 years from initial treatment – Periodontics (scaling & root planing, soft tissue & bony surgery, including grafts) - limitation of 2-3 years apply based on services rendered; periodontal cleaning subject to benefit limitation for regular cleaning – Denture repair & recementation of existing crowns, bridges & dentures - cost limited to ½ cost of new denture or prosthesis	80%	50%	50%	50%	50%	50%	
MAJOR DENTAL CARE – Crowns - (single crowns) - once per tooth every 5 years & only when existing crown cannot be rendered serviceable; benefit available only if the tooth is damaged by decay or fractured to the point it cannot be restored by an amalgam or composite restoration; crowns for dependents under the age of 12 not covered – Prosthodontics (partial or complete dentures & fixed bridges) - once every five years & only when existing prosthesis cannot be rendered serviceable; fixed bridges or removable partials are not benefits for dependents under age 16 – Implants	50%	50%	50%	50%	50%	50%	
ORTHODONTICS ***These services are exempt from deductible.*** – For subscribers & covered dependents	50%	50%	50%	NOT COVERED			
Lifetime Orthodontic Maximum	$1,500 per patient			NOT COVERED			*Fixed copayments*
OUT-OF-POCKET EXPENSES	Lowest	Low	Highest	Lowest	Low	Highest	*Fixed copayments*
DENTIST NETWORK	You may use any dentist. Your out-of-pocket expenses will vary based on which, if any, network your Dentist is in.			You may use any dentist. Your out-of-pocket expenses will vary based on which, if any, network your Dentist is in.			*Your DeltaCare panel dentist must be utilized for care. Specialty care is only available through Delta Dental's referral process.*
CALENDAR YEAR MAXIMUM	$1,500 per patient per calendar year						*No calendar year maximum*
ANNUAL DEDUCTIBLE	$50 per patient per calendar year: $150 per family unit						No annual deductible

2017 Premiums

Employee Premium Deductions	Delta Dental High Option Plan			Delta Dental Low Option Plan			DeltaCare Program		
	Bi-weekly	12-Pay	10-Pay	Bi-weekly	12-Pay	10-Pay	Bi-weekly	12-Pay	10-Pay
Employee Only	16.34	32.68	39.22	10.95	21.90	26.28	9.08	18.16	21.79
Employee/Spouse	29.56	59.12	70.94	19.80	39.60	47.52	15.12	30.24	36.29
Employee/Child	29.56	59.12	70.94	19.80	39.60	47.52	15.12	30.24	36.29
Employee/Family	46.41	92.82	111.38	31.07	62.14	74.57	20.41	40.82	48.98

Delta Dental of Virginia
4818 Starkey Road, Roanoke, VA 24018
Phone: (540) 989-8000 Fax: (540) 776-8109

Questions & Answers
Henrico County General Government and Public Schools
Group Number 600084

1. **Are there any changes to the Delta Dental plans this year?**
   No, there will be no changes to the Delta Dental plans effective January 1, 2017.

2. **Who needs to enroll?**
   New enrollees or current subscribers who wish to make any changes to their dental coverage. Current subscribers who are not making changes to their coverage do not need to re-enroll.

3. **Is there a choice of dental plans?**
   Yes. There are three plan options. You may choose from the Delta Dental High Option, Delta Dental Low Option, or DeltaCare program. The "Summary of Plan Benefits" chart will help you make your decision on which dental plan is right for you.

4. **How to select the right dental plan for your dental needs?**
   Whether your dental plan selection is based on monthly premium cost or for the flexibility of choosing your dentist, understanding the differences between the DeltaCare program and Delta Dental High and Low Option plans will help you to make an informed decision.

   Under the DeltaCare program you are required to select a DeltaCare panel dentist for your care when you enroll. You must receive all of your covered dental services from this provider. A participating DeltaCare orthodontist must provide orthodontic treatment. You pay set copayments for dental procedures. The DeltaCare program has the lowest payroll deduction of the three dental plan options.

   The Delta Dental High and Low Option plans allow you to select any 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 Option 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. Your payroll deduction for the High Option is slightly higher than the Low Option, but you will pay less out of pocket for certain services when you see the dentist.

5. **If I choose a DeltaCare provider, can I change my selection at any time?**
   You may change your DeltaCare provider. You MUST notify the DeltaCare program at 1-800-862-0838 by the 15th day of a month to have the change effective the first day of the next month.

6. **If I choose DeltaCare coverage, will I have coverage if I visit a dentist other than my selected DeltaCare provider?**
   No. Services must be rendered by your designated dentist. Your DeltaCare provider may refer you to another provider for specialized treatments with written authorization from the DeltaCare program.

7. **What are the differences between the Delta Dental High and Low Option plans?**
   The Delta Dental High and Low Option plans differ in the percentage of your dentist's charges that Delta Dental will pay. Under the High Option, dental services are covered at a higher level than the Low Option. In addition, orthodontics is a covered benefit under the High Option. The Low Option *does not* cover orthodontics. If you or any of your covered dependents are considering orthodontic treatment you should strongly consider the High Option.

8. **What is the difference between Delta Dental PPO Network dentists and Delta Dental Premier Network dentists?**
   There are two types of network dentists under the Delta Dental High and Low Option plans – Delta Dental PPO and Delta Dental Premier dentists. Both networks have agreed to accept Delta Dental's reimbursement allowance. However, you will receive the maximum plan benefits (and pay the lowest out-of-pocket costs) when you obtain services from a Delta Dental PPO dentist. A dentist in either network will file your claim for you and will accept Delta Dental's payment, plus any required employee coinsurance and any applicable deductible as payment in full.

   It is important to determine the network (Delta Dental PPO or Delta Dental Premier) in which your dentist participates so that you can know your out-of-pocket costs.

9. **What will happen if I go to a dentist not in the Delta Dental PPO or Delta Dental Premier networks if I have chosen the High or Low Option plan?**
   Payment is made directly to you and is based on the out-of-network reimbursement schedule. You will be responsible for paying the difference between out-of-network dentists' charges and Delta Dental's payment. You may also have to pay the out-of-network dentists in advance for the entire bill and may have to file the claim with Delta Dental. Benefits are lower when visiting an out-of-network dentist.

10. **How can I find out if my dentist participates with Delta Dental's networks if I have chosen a Delta Dental High or Low Option plan?**
    There are several ways to determine if your dentist participates in Delta Dental's networks:
    - Check Delta Dental's Internet website at www.deltadentalva.com.
    - Call Delta Dental's Benefit Services Representatives at 1-800-237-6060. They are available Monday – Thursday 8:15 a.m. – 6:00 p.m. EST and Friday 8:15 a.m. to 4:45 p.m. EST.
    - Ask your dentist if he/she is a participating dentist. **Be sure to ask if your dentist participates in the Delta Dental PPO and/or Delta Dental Premier networks.**

11. **How can my dentist enroll in Delta Dental's networks?**
    Your dentist can contact Delta Dental of Virginia at www.deltadentalva.com or contact Delta Dental's Provider Relations Department at 1-800-237-6060.

12. **Will I receive an ID card?**
    New subscribers and current subscribers making plan changes will receive two new ID cards. Current subscribers who are not making changes can continue to use their current ID cards. Additional ID cards may be obtained by calling Delta Dental's Benefit Services Department at 1-800-237-6060 (Delta Dental High or Low Option plans) or 1-800-862-0838 (DeltaCare program) or by visiting Delta Dental's website at www.deltadentalva.com.

13. **What should I do for my first dental appointment if I have chosen a Delta Dental High or Low Option plan?**
    - Tell the dentist you are covered by Delta Dental of Virginia.
    - Present your ID card or give the dentist your Subscriber Number.
    - Claim forms are typically filed directly by dental offices. Delta Dental accepts any standard ADA approved claim form.

14. **How can I avoid unexpected charges for dental care if I choose the Delta Dental High or Low Option plan?**
    - See a participating Delta Dental PPO or Delta Dental Premier dentist.
    - File a claim for pre-determination (not required but recommended for services over $250).
    - Call Delta Dental's Benefit Services Representatives with any benefit clarification questions.

15. **What is pre-determination and is it required under Delta Dental's High and Low Option plans?**
Pre-determination is a process that helps you find out what your potential costs may be for a particular dental procedure. Your dentist can file a claim for pre-determination of benefits with Delta Dental to determine what your plan will cover and what you may have to pay. Pre-determination is not required but is recommended for any procedures that are expected to cost $250 or more.

16. **Will the Delta Dental High and Low Option plans pay for all treatment options for my dental condition?**
Not in every situation. If you and your dentist agree on a procedure that is more expensive than the standard ADA recommended service to restore a tooth to contour and function, then Delta Dental will usually pay only the amount for the standard procedure. You would then be responsible for the entire balance of the dentist's fee for the more expensive service.

17. **How will Delta Dental pay orthodontia claims for individuals who are currently receiving orthodontia benefits from their previous dental carrier?**
If you are a new subscriber in the High Option 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. Orthodontia is not covered under the Low Option Plan. For new subscribers in DeltaCare, there is no benefit available for orthodontic treatment in progress.

18. **How can I access my benefit information online?**
If you are a subscriber of the Delta Dental High or Low Option Plans **only**, simply log in to our secure website at www.deltadentalva.com with your user name and password. If you are not already registered, click the link for "New user" and follow the instructions to select your user name and password. Once you have logged in to our secure website under Subscriber Connection, you will be able to access all your valuable benefits information.
    - ❖ Print replacement ID cards in the event you lose or misplace your ID card.
    - ❖ View and/or print the Member Handbook and Evidence of Coverage (EOC).
    - ❖ Track the status of your dental claims.
    - ❖ Verify your benefits including, benefit design, eligibility, maximum and deductible amounts.

19. **Are there any added benefits available under the Delta Dental High Option, Delta Dental Low Option or DeltaCare program?**
Yes, there are additional benefits available to subscribers and their family members enrolled in the Delta Dental High or Low Option Plans **only**.

    - ❖ The **Healthy Smile, Healthy You®** program offers additional benefits for three important health conditions connected to oral health: pregnancy, diabetes and certain high risk cardiac conditions. Members who have one of these conditions may enroll in the program to become eligible for one additional cleaning and exam (or periodontal maintenance procedure if you have a history of periodontal surgery) beyond the ordinary limit per benefit period. It's easy to enroll in the program, simply obtain the one page enrollment form from Delta Dental's website www.deltadentalva.com or call Delta Dental's Benefit Services Department at 1-800-237-6060.

    - ❖ **Prevention First** is another added benefit available to members enrolled in the Delta Dental High or Low Option Plans. With this benefit, visits to the dentist for diagnostic services and preventive care (typically x-rays, exams and cleanings) will no longer count against your calendar year benefit maximum. Instead, you will be rewarded with the entire calendar year benefit maximum amount for other covered services you may need throughout the plan year.

Delta Dental High and Low Option Plans and DeltaCare Program

Examples of Payments

Dentist charges below are estimates and used only to illustrate the potential difference in your out-of-pocket costs with each of the three Delta Dental Options and with dentists in different networks. These examples do not include any applicable deductible amounts.

Example 1: Periodic oral evaluation (D0120) and prophylaxis (cleaning) - adult (D1110)

Delta Dental High Option Plan

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Out-of-Network Dentist
Dentist Charges	$136.00	$136.00	$136.00
Delta Dental's Allowable Charges	$80.00	$104.00	$78.00
Plan Coverage Percentage	100%	100%	80%
Delta Dental's Payment	$80.00	$104.00	$62.40
Network Savings	$56.00	$32.00	$0.00
Estimated Out-of-Pocket Expenses	**$0.00**	**$0.00**	**$73.60**

Delta Dental Low Option Plan

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Out-of-Network Dentist
Dentist Charges	$136.00	$136.00	$136.00
Delta Dental's Allowable Charges	$80.00	$104.00	$78.00
Plan Coverage Percentage	75%	75%	75%
Delta Dental's Payment	$60.00	$78.00	$58.50
Network Savings	$56.00	$32.00	$0.00
Estimated Out-of-Pocket Expenses	**$20.00**	**$26.00**	**$77.50**

DeltaCare Program

Employee's Copayment to DeltaCare Dentist	**$0.00**

Example 2: Resin-based composite filling, one surface, posterior (2391)

Delta Dental High Option Plan

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Out-of-Network Dentist
Dentist Charges	$168.00	$168.00	$168.00
Delta Dental's Allowable Charges	$100.00	$132.00	$96.00
Plan Coverage Percentage	80%	50%	50%
Delta Dental's Payment	$80.00	$66.00	$48.00
Network Savings	$68.00	$36.00	$0.00
Estimated Out-of-Pocket Expenses	**$20.00**	**$66.00**	**$120.00**

Delta Dental Low Option Plan

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Out-of-Network Dentist
Dentist Charges	$168.00	$168.00	$168.00
Delta Dental's Allowable Charges	$100.00	$132.00	$96.00
Plan Coverage Percentage	50%	50%	50%
Delta Dental's Payment	$50.00	$66.00	$48.00
Network Savings	$68.00	$36.00	$0.00
Estimated Out-of-Pocket Expenses	**$50.00**	**$66.00**	**$120.00**

DeltaCare Program

Employee's Copayment to DeltaCare Dentist	**$35.00**

Example 3: Crown, porcelain fused to high-noble metal (D2750)

Delta Dental High Option Plan

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Out-of-Network Dentist
Dentist Charges	$1,050.00	$1,050.00	$1,050.00
Delta Dental's Allowable Charges	$694.00	$882.00	$685.00
Plan Coverage Percentage	50%	50%	50%
Delta Dental's Payment	$347.00	$441.00	$342.50
Network Savings	$356.00	$168.00	$0.00
Estimated Out-of-Pocket Expenses	**$347.00**	**$441.00**	**$707.50**

Delta Dental Low Option Plan

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Out-of-Network Dentist
Dentist Charges	$1,050.00	$1,050.00	$1,050.00
Delta Dental's Allowable Charges	$694.00	$882.00	$685.00
Plan Coverage Percentage	50%	50%	50%
Delta Dental's Payment	$347.00	$441.00	$342.50
Network Savings	$356.00	$168.00	$0.00
Estimated Out-of-Pocket Expenses	**$347.00**	**$441.00**	**$707.50**

DeltaCare

Employee's Copayment to DeltaCare Dentist	**$405.00**

DELTACARE – HENRICO

SCHEDULE A - DESCRIPTION OF BENEFITS AND COPAYMENTS (FIXED DOLLAR COPAYMENT)

The benefits shown below are performed as deemed appropriate by the attending DeltaCare 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 DeltaCare Dentist prior to services being rendered.

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA program and are not to be interpreted as CDT-2016 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.

CODES		COPAYMENT
I.	**DIAGNOSTIC**	
D0120	Periodic oral evaluation-established patient	No Cost
D0140	Limited oral evaluation—problem focused	No Cost
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
D0160	Detailed and extensive oral evaluation—problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0180	Comprehensive periodontal evaluation – new or established patient	$30.00
D0210	Intraoral - complete series of radiographic images – *limited to 1 series every 24 months*	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 images	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
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
II.	**PREVENTIVE**	
D1110	Prophylaxis *cleaning* – adult – 2 *per 12 month period*	No Cost
D1110	*Additional prophylaxis cleaning- adult (within the 12 month period)*	$41.00
D1120	Prophylaxis *cleaning* – child – 2 *per 12 month period*	No Cost
D1120	*Additional prophylaxis cleaning- child (within the 12 month period)*	$30.00
D1206	Topical application of fluoride varnish – *child to age 19; 1 D1206 or D1208 per 12 month period*	No Cost
D1208	Topical application of fluoride excluding varnish – *child to age 19; 1 D1206 or D1208 per 12 month period*	No Cost

CODES		COPAYMENT
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1510	Space maintainer - fixed - unilateral	$85.00
D1515	Space maintainer - fixed - bilateral	$85.00
D1555	Removal of fixed space maintainer	$10.00

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam -four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$75.00
D2390	Resin-based composite crown, anterior	$69.00
D2391	Resin-based composite – one surface, posterior	$35.00
D2392	Resin-based composite – two surfaces, posterior	$45.00
D2393	Resin-based composite – three surfaces, posterior	$65.00
D2394	Resin-based composite – four or more surfaces, posterior	$85.00
D2510	Inlay - metallic - one surface [*]	$360.00
D2520	Inlay - metallic - two surfaces [*]	$360.00
D2530	Inlay - metallic - three or more surfaces [*]	$360.00
D2542	Onlay - metallic - two surfaces [*]	$415.00
D2543	Onlay - metallic - three surfaces [*]	$415.00
D2544	Onlay - metallic - four or more surfaces [*]	$415.00
D2740	Crown - porcelain/ceramic substrate [†]	$445.00
D2750	Crown - porcelain fused to high noble metal [*][†]	$405.00
D2751	Crown - porcelain fused to predominately base metal [†]	$360.00
D2752	Crown - porcelain fused to noble metal [†]	$385.00
D2780	Crown - ¾ cast high noble metal [*]	$405.00
D2781	Crown - ¾ cast predominately base metal	$360.00
D2782	Crown - ¾ cast noble metal	$385.00
D2790	Crown - full cast high noble metal [*]	$405.00
D2791	Crown - full cast predominately base metal	$360.00
D2792	Crown - full cast noble metal	$385.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$35.00
D2920	Re-cement or re-bond crown	$35.00
D2930	Prefabricated stainless steel crown - primary tooth	$95.00
D2931	Prefabricated stainless steel crown - permanent tooth	$95.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$120.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$150.00
D2940	Protective restoration	No Cost
D2950	Core buildup, including any pins when required	$120.00
D2951	Pin retention - per tooth, in addition to restoration	$10.00
D2952	Post and core in addition to crown, indirectly fabricated [*]	$150.00
D2954	Prefabricated post and core in addition to crown – *base metal post; includes canal preparation*	$120.00
D2960	Labial veneer (resin laminate) - chairside	$65.00

CODES		COPAYMENT
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	$50.00
D3221	Pulpal debridement, primary and permanent teeth	$50.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$160.00
D3320	*Root canal* - endodontic therapy, bicuspid tooth (excluding final restoration)	$185.00
D3330	*Root canal* - endodontic therapy, molar (excluding final restoration)	$255.00
D3331	Treatment of root canal obstruction; non-surgical access	$70.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair of perforation defects	$70.00
D3346	Retreatment of previous root canal therapy - anterior	$210.00
D3347	Retreatment of previous root canal therapy - bicuspid	$240.00
D3348	Retreatment of previous root canal therapy - molar	$305.00
D3410	Apicoectomy - anterior	$190.00
D3421	Apicoectomy - bicuspid (first root)	$190.00
D3425	Apicoectomy - molar (first root)	$190.00
D3426	Apicoectomy (each additional root)	$75.00
D3430	Retrograde filling - per root	$50.00
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	$120.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$60.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces, per quadrant	$155.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces, per quadrant	$80.00
D4245	Apically positioned flap	$155.00
D4249	Clinical crown lengthening - hard tissue	$170.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$305.00
D4261	Osseous surgery (including elevation of full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$155.00
D4263	Bone replacement graft- first site in quadrant	$225.00
D4264	Bone replacement graft- each additional site in quadrant	$175.00
D4266	Guided tissue regeneration- resorbable barrier, per site	$295.00
D4267	Guided tissue regeneration- non-resorbable barrier, per site (includes membrane removal)	$335.00
D4270	Pedicle soft tissue graft procedure	$210.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$210.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	$210.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	$105.00
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	$126.00

CODES		COPAYMENT
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$60.00
D4342	Periodontal scaling and root planing – one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$30.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis- *limited to 1 treatment in any 12 consecutive months*	$45.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$60.00
D4910	Periodontal maintenance – *limited to 2 treatments each 12 month period*	$35.00
VI.	**PROSTHODONTICS, (removable)**	
D5110	Complete denture - maxillary [**]	$485.00
D5120	Complete denture - mandibular [**]	$485.00
D5130	Immediate denture - maxillary [**]	$485.00
D5140	Immediate denture - mandibular [**]	$485.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) [**]	$430.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) [**]	$430.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [**]	$560.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [**]	$560.00
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth) [**]	$430.00
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth) [**]	$430.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [**]	$560.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) [**]	$560.00
D5410	Adjust complete denture - maxillary	$30.00
D5411	Adjust complete denture - mandibular	$30.00
D5421	Adjust partial denture - maxillary	$30.00
D5422	Adjust partial denture - mandibular	$30.00
D5510	Repair broken complete denture base	$65.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$57.00
D5610	Repair resin denture base	$65.00
D5630	Repair or replace broken clasp - per tooth	$75.00
D5640	Replace broken teeth - per tooth	$63.00
D5650	Add tooth to existing partial denture	$65.00
D5660	Add clasp to existing partial denture - per tooth	$75.00
D5710	Rebase complete maxillary denture	$175.00
D5711	Rebase complete mandibular denture	$175.00
D5720	Rebase maxillary partial denture	$175.00
D5721	Rebase mandibular partial denture	$175.00
D5730	Reline complete maxillary denture (chairside)	$100.00
D5731	Reline complete mandibular denture (chairside)	$100.00
D5740	Reline maxillary partial denture (chairside)	$100.00
D5741	Reline mandibular partial denture (chairside)	$100.00
D5750	Reline complete maxillary denture (laboratory)	$150.00
D5751	Reline complete mandibular denture (laboratory)	$150.00
D5760	Reline maxillary partial denture (laboratory)	$150.00
D5761	Reline mandibular partial denture (laboratory)	$150.00
D5810	Interim complete denture (maxillary)	$229.00

CODES		COPAYMENT
D5811	Interim complete denture (mandibular)	$229.00
D5820	Interim partial denture (maxillary)	$198.00
D5821	Interim partial denture (mandibular)	$198.00

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 [*]	$405.00
D6211	Pontic - cast predominantly base metal	$360.00
D6212	Pontic - cast noble metal	$385.00
D6240	Pontic - porcelain fused to high noble metal [*][†]	$405.00
D6241	Pontic - porcelain fused to predominantly base metal [†]	$360.00
D6242	Pontic - porcelain fused to noble metal [†]	$385.00
D6245	Pontic - porcelain/ ceramic	$400.00
D6602	Retainer inlay - cast high noble metal, two surfaces [*]	$405.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces [*]	$405.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$360.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$360.00
D6606	Retainer inlay - cast noble metal, two surfaces	$385.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$385.00
D6610	Retainer onlay - cast high noble metal, two surfaces[*]	$405.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces[*]	$405.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$360.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$360.00
D6614	Retainer onlay - cast noble metal, two surfaces	$385.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$385.00
D6740	Retainer crown – porcelain / ceramic	$445.00
D6750	Retainer crown – porcelain fused to high noble metal [*][†]	$405.00
D6751	Retainer crown – porcelain fused to predominantly base metal [†]	$360.00
D6752	Retainer crown – porcelain fused to noble metal [†]	$385.00
D6780	Retainer crown – ¾ cast high noble metal [*]	$405.00
D6781	Retainer crown – ¾ cast predominantly base metal	$360.00
D6782	Retainer crown – ¾ cast noble metal	$385.00
D6790	Retainer crown – full cast high noble metal [*]	$405.00
D6791	Retainer crown – full cast predominantly base metal	$360.00
D6792	Retainer crown – full cast noble metal	$385.00
D6930	Re-cement or re-bond fixed partial denture	$18.00

X. ORAL AND MAXILLOFACIAL SURGERY
Includes preoperative and postoperative evaluations and treatment under a local anesthetic

D7111	Extraction, coronal remnants – deciduous teeth	$5.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$5.00
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$35.00
D7220	Removal of impacted tooth – soft tissue	$30.00
D7230	Removal of impacted tooth – partially bony	$65.00
D7240	Removal of impacted tooth – completely bony	$85.00
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$85.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$35.00

CODES		COPAYMENT
D7260	Oroantral fistula closure	$85.00
D7261	Primary closure of a sinus perforation	$85.00
D7270	Tooth re-implantation and/or stabilization if accidentally evulsed or displaced tooth	No Cost
D7280	Surgical access of an unerupted tooth	No Cost
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	$55.00
D7286	Incisional biopsy of oral tissue – soft	$45.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$40.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$55.00
D7450	Removal of benign odontogenic cyst or tumor- lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor- lesion diameter greater than 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7472	Removal of torus palatinus	No Cost
D7473	Removal of torus mandibularis	No Cost
D7485	Surgical reduction of osseous tuberosity	$55.00
D7510	Incision and drainage of abscess – intraoral soft tissue	No Cost
D7960	Frenulectomy – also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost

XI. ORTHODONTICS

D8050	Interceptive orthodontic treatment of the primary dentition - *banding*	$375.00
D8060	Interceptive orthodontic treatment of the transitional dentition - *banding*	$375.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - *banding*	$400.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *banding*	$400.00
D8090	Comprehensive orthodontic treatment of the adult dentition - - *banding*	$400.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$50.00
D8670	Periodic orthodontic treatment visit *(as part of contract)*	
	Children - up to 19th birthday; 24 month treatment fee	$1,500.00
	Charge per month for 24 months	$63.00
	Adults - 24 month treatment fee	$2,000.00
	Charge per month for 24 months	$83.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainers)	$300.00
D8999	Unspecified orthodontic procedure, by report	$150.00

Services include initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, debanding, and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of 24 months. For treatment plans extending beyond 24 months of active treatment, the Subscriber will be subject to an additional fee.

XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain-minor procedure	No Cost
D9223	Deep sedation/general anesthesia – each 15 minute increment	$65.00
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	$65.00
D9310	Consultation - diagnostic services provided by a dentist or physician other than requesting dentist or physician	No Cost
D9430	Office visit for observation (during regularly scheduled hours)- no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	$45.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9940	Occlusal guard, by report	$135.00

CODES		COPAYMENT
D9943	Occlusal guard adjustment	$30.00
D9951	Occlusal adjustment - limited	$25.00
D9952	Occlusal adjustment - complete	$140.00

Optional is defined as any alternative procedure presented by the DeltaCare Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the dental plan. The applicable charge to the Enrollee is the difference between the DeltaCare dentist's fee for the Optional procedure and the Plan Allowance for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when alternative choices are benefits. Questions regarding the DeltaCare dental plan should be directed to DeltaCare's Benefit Service department at (800) 862-0838. Services that are more expensive than the treatment usually provided under accepted dental practice standards or include the use of specialized techniques instead of standard procedures such as a crown where filling would restore a tooth or an implant in place of a fixed bridge or partial to restore a missing tooth are considered optional treatment. The patient must pay the difference in cost between the dentist's usual fees for the Covered Benefit and the optional or more expensive treatment plus any applicable Copayment.

If services for a listed procedure are performed by the assigned DeltaCare Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist services, and are referred by the assigned DeltaCare Dentist, must be preauthorized in writing by Delta Dental of Virginia. The Enrollee pays the Copayment specified for such services.

Procedures not listed above are not covered; however, may be available at the DeltaCare Dentist's Plan Allowance.

The above procedures are performed as needed and deemed necessary by your attending DeltaCare Dentist subject to the limitations and exclusions of the program. Please refer to those sections for further clarification of benefits.

The DeltaCare Dentist shall provide emergency dental care for a Covered Benefit which is required while an Enrollee is within 35 miles of the facility of the DeltaCare Dentist. If an Enrollee requires emergency dental care and is more than 35 miles from the facility of the DeltaCare Dentist, then Delta Dental of Virginia shall reimburse the Enrollee the cost of such emergency dental care which exceeds the Enrollee's Copayment up to a $50 maximum in a 12-month period. Emergency dental care shall be limited to listed procedures, and as described in code D9110 above: "Palliative (emergency) treatment of dental pain". Any further treatment of the cause of such emergency dental care must be preauthorized by Delta Dental or provided by the assigned DeltaCare Dentist.

*Base or noble metal is the Covered Benefit. If high noble metal (precious) is used for a crown, bridge, indirectly fabricated post and core, inlay or onlay, the Enrollee will be charged the additional laboratory cost of the high noble metal. An additional laboratory charge also applies to a titanium crown.

**Includes any adjustments for six months.

†Porcelain on molars is considered optional treatment.

Delta Dental High and Low Option plans
Limitations & Exclusions

LIMITATIONS

1. Oral exams are limited to twice in a Calendar Year.
2. Cleanings are limited to twice in a Calendar Year.
3. Periodontal cleanings are limited to twice in a Calendar Year.
4. 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.
5. Full mouth debridement is limited to once in a lifetime.
6. Fluoride applications are limited to twice in a Calendar Year for Dependents under the age of 19.
7. Bitewings X-rays are limited to twice in a Calendar Year; limited to a maximum of 4 films in one visit.
8. Full mouth/ panelipse X-rays are limited to once in a 5-year period.
9. A full mouth X-ray film includes bitewings X-rays; panoramic X-ray in conjunction with any other X-ray is considered a full mouth X-ray.
10. Sealants 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 3 year period.
11. Amalgam (silver) and composite (white) fillings are limited to once per surface in a 24-month period.
12. Space maintainers are limited to once per lifetime for Dependent children under the age of 14.
13. Retreatment of root canal therapy is a Covered Benefit 2 years after initial treatment.
14. Replacement of an existing crown is a Covered Benefit once every 5 years per tooth, and when the existing crown is not serviceable.
15. Recementation of existing crowns and inlays are limited to once in a 12 consecutive month period.
16. Replacement of an existing prosthetic is a Covered Benefit once every 5 years, and when the existing prosthesis is not serviceable.
17. Denture adjustments are limited to twice in a 12 consecutive month period.
18. Denture repair is limited to once in a 12 consecutive month period.
19. Implants are limited to once in a life-time per site for Enrollees over the age of 15.
20. Implants are limited to two per quadrant and four per each arch with a maximum of eight for full mouth reconstruction.
21. Stainless steel crowns are limited to primary (baby) teeth for participants under age 14.
22. Gingivectomy or gingivoplasty is limited to once per quadrant in a 36 month period.
23. Gingival flap procedures are limited to once per quadrant in a 36 month period.
24. Osseous surgery is limited to once per quadrant in a 36 month period.
25. Periodontal scaling and root planing is limited to once per quadrant in a 24 month period.
26. Periodontal services are limited 2-3 years based on services rendered.
27. Subepithelial connective tissue graft procedures; distal or proximal wedge procedure; soft tissue allograft; combined connective tissue and double pedicle graft procedures are limited to once per site in a 36 month period.
28. Fixed bridges or removable partials are limited to Dependents over the age of 15.
29. Crowns are a Covered Benefit when the tooth is damaged by decay or fractured and cannot be restored by amalgam or composite restoration.
30. Crowns are limited to Dependents over the age of 11.
31. Temporary prosthetic devices are not a separate benefit. Any charge for these devices is included in the fee for the permanent device.
32. Orthodontic benefits are limited to Dependents over the age of 4.
33. Bone harvesting is limited to once in a lifetime per tooth.
34. Adjustment, maintenance or cleaning of a maxillofacial prosthetic appliance is limited to once per year.

EXCLUSIONS

1. Services or supplies that are not dental services; also services not specifically listed as covered in the plan documents.
2. Services or treatment provided by someone other than a licensed dentist or a qualified licensed dental hygienist working under the supervision of a dentist.
3. A dental service that Delta Dental, in its sole discretion (subject to any and all internal and external appeals available to an enrollee), 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.

4. 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.
5. 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.
6. 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 you are enrolled under this dental plan.
7. 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 document.
8. Except as otherwise provided for in plan documents, prescription and non-prescription drugs; pre-medications; preventive control programs, oral hygiene instructions, and relative analgesia.
9. General anesthesia when less than three (3) teeth will be routinely extracted during the same office visit.
10. Splinting or devices used to support, protect, or immobilize oral structures that have loosened or been reimplanted, fractured or traumatized.
11. 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.
12. Charges to complete a claim form, copy records, or respond to Delta Dental's requests for information.
13. Charges for failure to keep a scheduled appointment.
14. Charges for consultations in person, by phone or other electronic means.
15. Charges for x-ray interpretation.
16. Dental services to the extent that benefits are available or would have been available if the enrollee 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.
17. Complimentary services or dental services for which you would not be obligated to pay in the absence of the coverage under the plan or any similar coverage.
18. Services or treatment provided to an immediate family member by the treating dentist. This would include a dentist's parent, spouse or child.
19. 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).
20. Dental services or other services that Delta Dental determines are for correcting congenital malformations; also, cosmetic surgery or dentistry for cosmetic purposes.
21. 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.
22. Experimental or investigative dental procedures, services, or 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.
23. 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.
24. Dental services, procedures and supplies needed because of harmful habits. An example of a harmful habit includes clenching or grinding of the teeth.
25. 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 for the underlying component codes.
26. 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's bases its payment on its determination of the more accurate dental service code.
27. Amounts assessed on dental services and/or supplies by state or local regulation.
28. Amounts that exceed the plan allowance as agreed to by the dentist for covered benefit.

DeltaCare Program
Limitations & Exclusions

LIMITATIONS

1. Prophylaxis is limited to one treatment each six month period (includes periodontal maintenance following active therapy);
2. Fluoride limited to two applications every 12 consecutive month period for dependents under age 19;
3. Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one each in any five year period from initial placement;
4. Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible;
5. Crown(s) and fixed partial dentures (bridges) are not to be replaced within any five year period from initial placement;
6. Denture relines are limited to one per denture during any 12 consecutive months;
7. Periodontal treatments (root planing/ subgingival curettage) are limited to four quadrants during any 12 consecutive months;
8. Full mouth debridement (gross scale) is limited to one treatment in any 12 consecutive month period;
9. Bitewing X-rays are limited to not more than one series of four films in any six month period;
10. A full mouth X-ray series (including any combination of periapicals or bitewings with a panoramic film) or a series of seven or more vertical bitewings is limited to one series every 24 months;
11. Benefits for sealants include the application of sealants only to the occlusal surface of permanent molars for patients through age 15. The teeth must be free from caries or restorations on the occlusal surface. Benefits include the repair or replacement of a sealant on any tooth within three years of its application by the same DeltaCare Dentist who placed the sealant;
12. Replacement of prosthetic appliances (bridges, partial or full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five year limitation for replacement;
13. Coverage is limited to the benefit customarily provided. Enrollee must pay the difference in cost between the Dentist's usual fees for the Covered Benefit and the optional or more expensive treatment plus any applicable Copayment;
14. Services that are more expensive than the treatment usually provided under accepted dental practice standards or include the use of specialized techniques instead of standard procedures, such as a crown where filling would restore a tooth or an implant in place of a fixed bridge or partial to restore a missing tooth, are considered Optional Treatment;
15. Composite resin restorations to restore decay or missing tooth structure that extend beyond the enamel layer are limited to anterior teeth (cuspid to cuspid) and facial surfaces of maxillary bicuspids;
16. A fixed partial denture (bridge) is limited to the replacement of permanent anterior teeth provided it is not in connection with a partial denture on the same arch, or duplicates an existing, non-functional bridge and it meets the five year limitation for replacement;
17. Stayplates, in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period or in children 16 years and under for missing anterior teeth;
18. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned DeltaCare Dentist to treat the child and upon prior authorization by Delta Dental, less applicable Copayments. Delta Dental will consider exceptions for medical conditions, regardless of age limitation, on an individual basis;
19. Porcelain crowns and porcelain fused to metal crowns on all molars are considered Optional Treatment;
20. Fixed bridges used to replace missing posterior teeth are considered Optional Treatment when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered optional dental treatment. The Enrollee must pay the difference in cost between the DeltaCare Dentist's Plan Allowance for the Covered Benefit and the Optional Treatment, plus any Copayment for the Covered Benefit.

EXCLUSIONS

The following are not Covered Benefits under any circumstance **unless specifically identified** as a Covered Benefit in the **Schedule A – Description of Benefits and Copayments:**

1. Except as otherwise specifically provided in the plan document, services or supplies provided by someone other than a DeltaCare Dentist or a qualified dental hygienist working under the supervision of a DeltaCare Dentist;
2. Services that would not be covered, if a DeltaCare Dentist provided them, regardless of who the Dentist is;
3. General anesthesia, IV sedation, and nitrous oxide and the services of a special anesthesiologist;
4. Dental procedures performed for purely cosmetic purposes;
5. Dental Services for injuries or conditions that may be covered under Worker's Compensation or similar employer liability laws; benefits or services that are available under any federal, state, or municipal government program (subject to the rules and regulations of those programs) or from any charitable foundation or similar entity; also services provided to the Enrollee without cost by any municipality, county or other political subdivision;
6. Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a dentist for treatment in any such facility;
7. Treatment of fractures, dislocations and subluxations of the upper or lower jaw. This includes therapy, surgery and appliances to correct temporomandibular joint (TMJ) dysfunction, problems, and/or occlusal disharmony (including occlusal equilibration).
8. Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures);
9. Dental Services started or provided before the date the Enrollee is enrolled under the EOC. Also, except as otherwise provided in this EOC, benefits for a course of treatment that began before the Enrollee is enrolled under this EOC.
10. Except as otherwise provided in this EOC, Dental Services provided after the date that the individual is no longer enrolled or eligible for coverage under this EOC;
11. Any service not specifically listed as a Covered Benefit in **Schedule A – Description of Benefits and Copayments.**
12. Correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function (unless mandated by state law);
13. Cysts and malignancies;
14. Prescription drugs;
15. Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits **subject to this EOC's terms, conditions, limitations, and other exclusions;**
16. Cases in which the treating Dentist has indicated a satisfactory result cannot be obtained or there is little or no likelihood of successful and lasting result based on the patient's dental condition;
17. Dental services received from any dental office other than the assigned DeltaCare dental office, unless expressly authorized in writing by Delta Dental or as cited under 'Emergency Service';
18. Prophylactic removal of impactions (asymptomatic, nonpathological);
19. "Consultations" for noncovered benefits;
20. Implant placement or removal of appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment;
21. Placement of a crown where there is sufficient tooth structure to retain a standard filling;
22. Porcelain crowns and porcelain fused to metal crowns on all molars;
23. Restorations placed due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth;
24. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered optional dental treatment. The patient must pay the difference in cost between the Dentist's usual fees for the covered benefit and plan allowance for the Optional Treatment, plus any Copayment for the Covered Benefit;
25. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnatholgic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ);
26. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework (major mouth reconstruction);
27. Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization;
28. Soft tissue management including without limitation irrigation, infusion, and any special toothbrush;
29. Diagnosis, treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services;
30. Restorative work caused by orthodontic treatment;
31. Extractions solely for the purpose of orthodontics; and

32. Specialist Services that Delta Dental has not authorized in writing in advance (except Covered Benefits for orthodontic services that a DeltaCare Orthodontist provides).

ORTHODONTIC LIMITATIONS

The DeltaCare dental plan provides coverage for orthodontic treatment plans provided by a DeltaCare Orthodontist. The cost to the Enrollee for the treatment plan is listed in **Schedule A – Description of Benefits and Copayments** subject to the following:

1. Orthodontic treatment must be provided by a DeltaCare Orthodontist.
2. Plan benefits cover 24 months of active comprehensive orthodontic treatment and include the initial examination, diagnosis, consultation, initial banding, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of 24 months.
3. For treatment plans extending beyond 24 months of active treatment, the Enrollee will be subject to a monthly office fee.
4. Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination, the Enrollee or Enrollee's dependent is receiving orthodontic treatment, the Enrollee and not Delta Dental will be solely responsible for treatment provided after cancellation or termination. In such a case, the Enrollee's payment shall be based on the Dentist's usual fee at the beginning of treatment. The amount will be pro-rated over the months until completion of the treatment and will be payable by the Enrollee on such terms and conditions as are arranged between the Enrollee and the Orthodontist.
5. If treatment is not required or the Enrollee chooses not to start treatment after the Orthodontist has completed the diagnosis and consultation, the Enrollee will be charged a consultation fee of $25 in addition to diagnostic record fees.
6. The Copayment is payable to the DeltaCare Orthodontist who initiates banding in a course of orthodontic treatment. If, after banding has been initiated, the Enrollee changes to another DeltaCare Orthodontist to continue orthodontic treatment the Enrollee will not be entitled to a refund of any amounts previously paid. In addition, the Enrollee will be responsible for all payments, up to and including the full Copayment, that is required by the new DeltaCare Orthodontist for completion of the orthodontic treatment.
7. Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are Covered Benefits. If any additional recementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost at the DeltaCare Orthodontist's Plan Allowance.

ORTHODONTIC EXCLUSIONS

The following are not Covered Benefits under any circumstance **unless specifically identified** as a Covered Benefit in the **Schedule A – Description of Benefits and Copayments:**

1. Orthodontic services provided by an Orthodontist who is not a DeltaCare Orthodontist;
2. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances;
3. Retreatment of orthodontic cases;
4. Changes in treatment necessitated by accident of any kind;
5. Surgical procedures incidental to orthodontic treatment;
6. Myofunctional therapy;
7. Surgical procedures related to cleft palate, micrognathia, or macrognathia;
8. Treatment related to temporomandibular joint disturbances (TMJ);
9. Supplemental appliances not routinely utilized in typical comprehensive orthodontics, including but not limited to: palatal expander, habit control appliance, pendulum, quad helix or herbst;
10. Restorative work caused by orthodontic treatment;
11. Active treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge;
12. Phase I orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I orthodontics is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition;
13. Extractions solely for the purpose of orthodontics;
14. Treatment in progress at inception of eligibility;
15. Patient initiated transfer after bands have been placed;
16. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

ENROLLMENT INSTRUCTIONS
(for paper enrollment)

1. **Review the benefits summary** to determine the plan best suited for your individual or family needs.

2. **Complete** the following information on the 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 **Delta Dental High or Low Option plan**:

      ⇨ Mark the **"Delta Dental High Option plan" or "Delta Dental Low Option plan"** box under ***"Product".***

   b) If you have chosen the **DeltaCare program**:

      ⇨ Mark the **"DeltaCare"** box under ***"Product"***.
      ⇨ **Select a dentist** from the DeltaCare Provider List***. You may not receive benefits of this plan until you have selected a DeltaCare panel dentist.***
      ⇨ Write the dentist's name and provider number on the enrollment form.

3. **Sign** and **date** the enrollment form and return to the Schools Benefits Office or the General Government's Department of Human Resources.

4. If you have any questions, please call the Schools Benefits Office at 804-652-3624 or the General Government's Department of Human Resources at 804-501-7371.

If you have any questions or need additional information,
call or write

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