

# Henrico County General Government and Public Schools

## Summary of Plan Benefits

Effective January 1, 2024

Plan Features for High and Low Option Plans	Delta Dental High and Low Option plans						EPO Plan
	High Option			Low Option			
	PPO Network	Premier Network	Out-of-Network	PPO Network	Premier Network	Out-of-Network	
<b>DIAGNOSTIC &amp; PREVENTIVE CARE/ PREVENTION FIRST</b> <i>These services are exempt from deductible and calendar year maximum.</i> <ul style="list-style-type: none"> <li>– Oral exams &amp; cleanings - 2/calendar yr</li> <li>– Periodontal cleanings- 2/calendar yr</li> <li>– Fluoride treatment - 2/calendar yr (under age 19)</li> <li>– Bitewing x-rays - 2/calendar yr</li> <li>– Full mouth/panelpipse x-rays - 1/ 5years</li> <li>– Space maintainers - dependents under age 14</li> <li>– Sealants - only non-carious, non-restored 1<sup>st</sup> &amp; 2<sup>nd</sup> permanent molars (under age 16; limited to one application per tooth every 3 years)</li> <li>– Healthy Smile, Healthy You <sup>™</sup>–Enrolled pregnant members and/or enrolled diabetic members are entitled to an additional cleaning or periodontal maintenance visit</li> </ul>	100%	100%	80%	75%	75%	75%	100%*
<b>BASIC DENTAL CARE</b> <ul style="list-style-type: none"> <li>– Restorative - amalgam (silver) fillings; composite (white) fillings</li> <li>– Stainless steel crowns - baby/primary teeth only for dependents under age 14</li> <li>– Oral surgery - simple extractions, impactions &amp; other minor surgical procedures</li> <li>– Endodontics (root canal therapy) - repeat treatment covered only after 2 years from initial treatment</li> <li>– Periodontics (scaling &amp; root planing, soft tissue &amp; bony surgery, including grafts) - limitation of 2-3 years apply based on services rendered; periodontal cleaning subject to benefit limitation for regular cleaning</li> <li>– Denture repair &amp; recementation of existing crowns, bridges &amp; dentures - cost limited to ½ cost of new denture or prosthesis</li> </ul>	80%	50%	50%	50%	50%	50%	Fixed Copayment
<b>MAJOR DENTAL CARE</b> <ul style="list-style-type: none"> <li>– Crowns - (single crowns) - once per tooth every 5 years &amp; 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</li> <li>– Prosthodontics (partial or complete dentures &amp; fixed bridges) - once every five years &amp; only when existing prosthesis cannot be rendered serviceable; fixed bridges or removable partials are not benefits for dependents under age 16</li> <li>– Implants</li> </ul>	50%	50%	50%	50%	50%	50%	Fixed Copayment
<b>ORTHODONTICS</b> <i>These services are exempt from deductible.</i> <ul style="list-style-type: none"> <li>– For subscribers &amp; covered dependents</li> </ul>	50%	50%	50%	NOT COVERED			50%
<b>Lifetime Orthodontic Maximum</b>	\$1,500 per patient			NOT COVERED			\$2,000/patient
<b>OUT-OF-POCKET EXPENSES</b>	Lowest	Low	Highest	Lowest	Low	Highest	
<b>DENTIST NETWORK</b>	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.			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.
<b>CALENDAR YEAR MAXIMUM</b>	\$1,500 per patient per calendar year						\$3,000/patient
<b>ANNUAL DEDUCTIBLE</b>	\$50 per patient per calendar year: \$150 per family unit						No annual deductible

# Delta Dental High and Low Option Plans and Delta Dental PPO™- EPO Plan Design

## 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™	Delta Dental Premier®	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
<b>Estimated Out-of-Pocket Expenses</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$73.60</b>

#### *Delta Dental Low Option Plan*

	Delta Dental PPO™	Delta Dental Premier®	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
<b>Estimated Out-of-Pocket Expenses</b>	<b>\$20.00</b>	<b>\$26.00</b>	<b>\$77.50</b>

#### *Delta Dental PPO™- EPO Plan*

	Delta Dental PPO™	Delta Dental Premier®	Out-of-Network
Dentist's Charge for Covered Procedures	\$136.00	\$136	\$136
Delta Dental's Plan Allowance	\$80.00	\$0	\$0
Patient Copayment	\$0	N/A	N/A
Delta Dental's Payment	\$80.00	\$0	\$0
Patient Payment	\$0	\$0	\$0
<b>Amount Dentist Receives</b>	<b>\$80.00</b>	<b>\$136</b>	<b>\$136</b>

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

#### *Delta Dental High Option Plan*

	Delta Dental PPO™	Delta Dental Premier®	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
<b>Estimated Out-of-Pocket Expenses</b>	<b>\$20.00</b>	<b>\$66.00</b>	<b>\$120.00</b>

**Delta Dental Low Option Plan**

	Delta Dental PPO™	Delta Dental Premier®	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
<b>Estimated Out-of-Pocket Expenses</b>	<b>\$50.00</b>	<b>\$66.00</b>	<b>\$120.00</b>

**Delta Dental PPO™ - EPO Plan**

	Delta Dental PPO™	Delta Dental Premier®	Out-of-Network Dentist
Dentist's Charge for Covered Procedures	\$168.00	\$168.00	\$168.00
Delta Dental's Plan Allowance	\$100.00	\$0	\$0
Patient Copayment	\$35	N/A	N/A
Delta Dental's Payment	\$65.00	\$0	\$0
Patient Payment	\$35.00	\$0	\$0
<b>Amount Dentist Receives</b>	<b>\$100.00</b>	<b>\$168.00</b>	<b>\$168.00</b>

**Example 3: Crown, porcelain fused to high-noble metal (2750)****Delta Dental High Option Plan**

	Delta Dental PPO™	Delta Dental Premier®	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
<b>Estimated Out-of-Pocket Expenses</b>	<b>\$347.00</b>	<b>\$441.00</b>	<b>\$707.50</b>

**Delta Dental Low Option plan**

	Delta Dental PPO™	Delta Dental Premier®	Out-of-Network Dentist
Dentist Charges	\$1,050.00	\$1,050.00	\$1050.00
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
<b>Estimated Out-of-Pocket Expenses</b>	<b>\$347.00</b>	<b>\$441.00</b>	<b>\$707.50</b>

**Delta Dental PPO™ - EPO Plan**

	Delta Dental PPO™	Delta Dental Premier®	Out-of-Network Dentist
Dentist's Charge for Covered Procedures	\$1,050.00	\$1,050.00	\$1,050.00
Delta Dental's Plan Allowance	\$694.00	\$0	\$0
Patient Copayment	\$405.00	N/A	N/A
Delta Dental's Payment	\$289.00	\$0	\$0
Patient Payment	\$405.00	\$0	\$0
<b>Amount Dentist Receives</b>	<b>\$694.00</b>	<b>\$1,050.00</b>	<b>\$1,050.00</b>