DELTA DENTAL

VIRGINIA BANKERS ASSOCIATION
Benefits Corporation

# Delta Dental PPO Plus Premier

**Benefits for VBA Benefits Corporation**

**Indemnity Plan**

**Group Number: 600185**

**Effective Date: January 1, 2020**

| | |
|---|---|
| **Annual Deductible** *(Applies to Basic and Major Services)* | $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 |
| **Prevention First** | Visits to the dentist for Diagnostic and Preventive Services will not count against the Annual Maximum. |
| ***LifeSmile℠+HOW®*** | Your plan provides additional benefits to enrollees who are at greater risk of oral diseases or medical complications related to oral health. Benefit enhancements for patients at greater risk for oral disease may include oral health counseling, tooth decay susceptibility testing, sealants for children and adults, and greater frequency of cleanings, periodontal maintenance, and fluoride treatments. To determine if you are eligible, you must request to have a standardized clinical risk assessment completed by your dentist. |

**Covered Benefits**

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

| Coverage | Coinsurances | | | Benefit Limitations |
|---|---|---|---|---|
| | In-Network | | Out-of-Network | |
| | PPO | Premier | | |
| **Diagnostic and Preventive Services** | 100% | 100% | 100% | |
| • Oral exams and cleanings | | | | Twice each in a calendar year. |
| • Periodontal cleanings | | | | Twice in a calendar year. |
| • Fluoride applications | | | | Twice in a calendar year for enrollees under the age of 19. |
| • Bitewing X-rays | | | | One set in a calendar year. |
| • Full mouth/panelipse X-rays | | | | Once in a 5-year period. |
| • Sealants | | | | One application per tooth for enrollees under the age of 16 on non-carious, non-restored 1st and 2nd permanent molars. |
| • Space maintainers | | | | Once per quadrant per arch for enrollees under the age of 14. |
| **Basic Services** | 80% | 80% | 80% | |
| • Amalgam (silver) and composite (white) fillings | | | | Once per surface in a 24-month period. |
| • Stainless steel crowns | | | | Primary (baby) teeth for enrollees under the age of 14. |
| • Simple extractions | | | | |
| • Complex oral surgery | | | | Surgical extractions and other surgical procedures. |

| Covered Benefits<br>Delta Dental will pay the stated percentage of the plan allowance based on the dentist's participation with Delta Dental. | | | | |
|---|---|---|---|---|
| **Coverage** | **Coinsurances** | | | **Benefit Limitations** |
| | **In-Network** | | **Out-of-Network** | |
| | **PPO** | **Premier** | | |
| • Endodontic services/root canal therapy<br>• Periodontic services | | | | Retreatment only after 24 months from initial root canal therapy treatment.<br>Once per quadrant in a 24-36 month period based on services rendered. |
| **Basic Services continued** | **80%** | **80%** | **80%** | |
| • Occlusal Guards<br>• TMJ | | | | Once per person per lifetime<br>Once per person per lifetime |
| **Other Basic Services** | **50%** | **50%** | **50%** | |
| • Denture repair and recementation of crowns, bridges and dentures | | | | Once in a 12-month period after 6 months from initial placement. |
| **Major Services** | **50%** | **50%** | **50%** | |
| • Crowns<br>• Prosthodontics, removable and fixed<br>• Implants | | | | Once per tooth in a 7 year period for enrollees age 12 and older.<br>Once in a 7 year period for enrollees age 16 and older.<br>Once per site for enrollees age 16 and older. |
| **Orthodontic Services** | **50%** | **50%** | **50%** | |
| • Treatment for the proper alignment of teeth | | | | For dependent children under the age of 19. |

## COVERAGE IS AVAILABLE FOR

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

## CHOOSING A DENTIST

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

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

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

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

The following chart illustrates how choosing a network dentist helps you save on out-of-pocket costs.

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

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

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