

Benefits for Fairfax County Government
Group Number: 600050
Effective Date: January 1, 2021

Annual Deductible (<i>Applies to Basic, Major, and Orthodontic Services</i>)	\$50 per person; \$150 per family, per calendar year
Annual Maximum	\$2,000 per enrollee, per calendar year
Orthodontic Lifetime Maximum	\$2,000 per person
Prevention First	Visits to the dentist for Diagnostic and Preventive Services will not count against the Annual Maximum.
<i>Healthy Smile, Healthy You</i> ® Program	Your plan provides additional cleanings and/or application of topical fluoride to enrollees with specific health conditions such as pregnancy, diabetes, high-risk cardiac conditions or who are undergoing cancer treatment via chemotherapy and/or radiation. Enrollment in the <i>Healthy Smile, Healthy You Program</i> is simple. Visit DeltaDentalVA.com to print an enrollment form.

Covered Benefits				
Delta Dental will pay the stated percentage of the plan allowance based on the dentist's participation with Delta Dental.				
Coverage	Coinsurances			Benefit Limitations
	In-Network		Out-of-Network	
	PPO	Premier		
Diagnostic and Preventive Services	100%	100%	80%	
<ul style="list-style-type: none"> Oral exams Regular/Periodontal cleanings Fluoride applications Bitewing X-rays Full mouth/panelpulse X-rays Sealants Space maintainers 				Twice in a calendar year. Limited to four in a calendar year (maximum of 2 regular cleanings). 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 films or a set (7-8 films) of vertical bitewings. Once in a 5-year period. One application per tooth in a 60-month period for enrollees under the age of 19 on non-carious, non-restored 1 st and 2 nd permanent molars. Once per quadrant per arch for enrollees under the age of 14.
Basic Services	90%	80%	80%	
<ul style="list-style-type: none"> Amalgam (silver) and composite (white) fillings Stainless steel crowns Simple extractions Denture repair and recementation of crowns, bridges and dentures 				Once per surface in a 24-month period. Primary (baby) teeth for enrollees under the age of 14. Once in a 12-month period after 6 months from initial placement.
Other Basic Services	60%	50%	50%	
<ul style="list-style-type: none"> Endodontic services/root canal therapy 				Retreatment only after 24 months from initial root canal therapy treatment.

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Coverage	Coinsurances			Benefit Limitations
	In-Network		Out-of-Network	
	PPO	Premier		
Other Basic Services	60%	50%	50%	
<ul style="list-style-type: none"> • Periodontic services • Complex oral surgery 				Once per quadrant in a 24-36 month period based on services rendered. Surgical extractions and other surgical procedures.
Major Services	60%	50%	50%	
<ul style="list-style-type: none"> • Crowns • Prosthodontics, removable and fixed • Implants • TMJ 				Once per tooth every 7 years for enrollees age 12 and older. Once every 7 years for enrollees age 16 and older. Once per site for enrollees age 16 and older. Occlusal orthotic device
Orthodontic Services	50%	50%	35%	
<ul style="list-style-type: none"> • Treatment for the proper alignment of teeth 				For dependent children through the end of the month they reach age 19.

COVERAGE IS AVAILABLE FOR

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

CHOOSING A DENTIST

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

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

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

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

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.