

**Benefits for Arlington Public Schools
Group Number: 6112
Effective Date: January 1, 2017**

Annual Deductible <i>(Applies to Basic and Major Services)</i>	\$50 per person; \$100 per family, per calendar year
Annual Maximum	\$1,500 per enrollee, per calendar year
Orthodontic Lifetime Maximum	\$1,500 per person
Healthy Smile, Healthy You[®] 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.

Covered Benefits and Coinsurance

(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
	PPO	Premier		
Diagnostic and Preventive Services	100%	100%	100%	
<ul style="list-style-type: none"> • Oral exams and cleanings • Fluoride applications • Bitewing X-rays • Full mouth/panelpipe X-rays • Sealants • Space maintainers 				<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>Once in a calendar year for enrollees under the age of 19.</p> <p>One set in a calendar year.</p> <p>Once in a 3-year period.</p> <p>One application per tooth for enrollees under the age of 16 on non-carious, non-restored 1st and 2nd permanent molars.</p> <p>Once per quadrant per arch for enrollees under the age of 14.</p>
Basic Services	80%	80%	80%	
<ul style="list-style-type: none"> • Amalgam (silver) and composite (white) fillings • Stainless steel crowns • Simple extractions • Endodontic services/root canal therapy • Periodontic services • Complex oral surgery • Denture repair and recementation of crowns, bridges and dentures 				<p>Once per surface in a 24-month period.</p> <p>Primary (baby) teeth for enrollees under the age of 14.</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>Surgical extractions and other surgical procedures.</p> <p>Once in a 12-month period after 6 months from initial placement.</p>

Covered Benefits and Coinsurance

(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
	PPO	Premier		
Major Services	65%	65%	65%	
<ul style="list-style-type: none"> • Crowns • Prosthodontics, removable and fixed • Implants 				Once per tooth in a 60-month period for enrollees over the age of 11. Once in a 60-month period for enrollees over the age of 15. Once per site for enrollees over the age of 15.
Orthodontic Services	50%	50%	50%	
<ul style="list-style-type: none"> • Treatment for the proper alignment of teeth 				For subscriber and covered dependents.

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 Virginia law requires otherwise.

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	\$1,200.00	\$1,200.00	\$1,200.00
Delta Dental's Plan Allowance	\$729.00	\$925.00	\$925.00
Coinsurance Percentage	50%	50%	50%
Delta Dental's Payment	\$364.50	\$462.50	\$462.50
Patient Payment*	\$364.50	\$462.50	\$737.50

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.