

**Benefits for Montgomery County High Plan
Group Number: 700223
Effective Date: October 1, 2016**

| | |
|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Annual Deductible | N/A |
| Annual Maximum | \$1,500 per enrollee, per contract 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 | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| Delta Dental will pay the stated percentage of the plan allowance based on the dentist's participation with Delta Dental. | | | |
| <u>Coverage</u> | <u>Coinsurance</u> | <u>Benefit Limitations</u> | <u>Benefit Waiting Period</u> |
| Diagnostic and Preventive Services | 100% | | None |
| <ul style="list-style-type: none"> • Oral exams and regular cleanings • Periodontal cleanings • Fluoride applications • Bitewing X-rays • Full mouth/panelpipse X-rays • Sealants • Space maintainers | | Twice in a 12 consecutive month period. Twice in a 12 consecutive month period. Twice in a 12 consecutive month period for enrollees under the age of 19. One set in a 12 consecutive month period. Once in a 5-year period. One application per tooth for enrollees under the age of 16 on non-carious, non-restored 1 st and 2 nd permanent molars, once every 5 years. Once per quadrant per arch for enrollees under the age of 14. | |
| Basic Services | 80% | | None |
| <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 | | Once per surface in a 24-month period; Composite (white) fillings are limited to the upper and lower 6 front teeth. Primary (baby) teeth for enrollees under the age of 14. Retreatment only after 24 months from initial root canal therapy treatment. Once per quadrant in a 24-36 month period based on services rendered. Surgical extractions and other surgical procedures. Once in a 12-month period after 6 months from initial placement. | |

Covered Benefits

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| <u>Coverage</u> | <u>Coinsurance</u> | <u>Benefit Limitations</u> | <u>Benefit Waiting Period</u> |
|-----------------------------------------------------------------------------------------------------------|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| Major Services | 50% | | None |
| <ul style="list-style-type: none"> • Crowns • Prosthodontics, removable and fixed | | <p>Once per tooth in an 84-month period for enrollees over the age of 11.</p> <p>Once in an 84-month period for enrollees over the age of 15.</p> | |
| Orthodontic Services | 50% | | None |
| <ul style="list-style-type: none"> • Treatment for the proper alignment of teeth | | For dependent children under the age of 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 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 Premier dentist 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.

| | <u>Premier Network Dentist</u> | <u>Non-Participating Dentist</u> |
|----------------------------------------|--------------------------------|----------------------------------|
| Dentist's Charge for Covered Procedure | \$1,200.00 | \$1,200.00 |
| Delta Dental's Plan Allowance | \$925.00 | \$705.00 |
| Coinsurance Percentage | 50% | 50% |
| Delta Dental's Payment | \$462.50 | \$352.50 |
| Patient Payment* | \$462.50 | \$847.50 |

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.