Evidence of Coverage

Delta Dental Premier

Dental Benefits

for

SURA/Jefferson Science Associates

Group Number: 6098

Delta Dental of Virginia
4818 Starkey Road
Roanoke, Virginia 24018
Telephone: (800) 237-6060

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1.0 INTRODUCTION

This is your Evidence of Coverage. It is also referred to as your EOC. This EOC is part of your Group's Contract. All of the provisions in this EOC are subject to the terms, conditions, and limitations of your Group's Contract.

Delta Dental of Virginia provides your coverage. Delta Dental's plans are designed to make Covered Benefits more affordable. In most cases, this plan will pay a portion of your Covered Benefits' costs. The plan does not pay all your costs. You may be responsible for Deductibles, Co-insurances, and some Dentists' charges that exceed what Delta Dental pays.

As a Managed Care Health Insurance Plan operating in the Commonwealth of Virginia, Delta Dental is subject to regulation by both the Virginia State Corporation Bureau of Insurance (pursuant to Title 38.2 of the Code of Virginia) and the Virginia Department of Health (pursuant to Title 32.1 of the Code of Virginia).

2.0 WHAT ARE MY DENTAL BENEFITS?

This is a summary of your Covered Benefits. A detailed listing of Covered Benefits is in Delta Dental's covered procedure code list. To receive a copy of this list, please call a Delta Dental customer service representative at **800-237-6060**. All Covered Benefits are subject to the limitations described in this section and elsewhere in the Contract. The limitations in this section are based on frequency or duration of services, age and similar criteria. For additional benefit limitations, please see the sections in this EOC entitled "What other payment rules affect my coverage" and "What is excluded". All limitations are part of the dental program that your Group has selected.

A Dentist must provide all Covered Benefits. There are four exceptions. A qualified dental hygienist may provide Covered Benefits for (1) cleaning or scaling your teeth, (2) applying fluoride directly (i. e. "topically") to your teeth, (3) administering oral anesthetics topically, and (4) applying antimicrobial agents topically for the treatment of periodontal pocket lesions. To be covered, the dental hygienist's services (1) must be supervised and guided by a Dentist whose services would also be covered under this Contract; (2) must be provided in accordance with generally accepted dental practice standards and the laws and the regulations of the state or other jurisdiction in which the services are

provided; and (3) are subject to all other terms, conditions, exclusions, and limitations in the Contract.

A qualified Delta Dental dental reviewer may review any claim before it is paid. Among other things, he or she will determine generally accepted dental practice standards when that is a coverage criterion. Delta Dental also uses its own standard processing policies to determine which Dental Services are Covered Benefits. In-network and out-of-network services are paid in accordance with Delta Dental's processing policies.

TYPES OF SERVICES	DESCRIPTION OF BENEFITS	LIMITATIONS
Diagnostic & Preventive Care:	Oral exams & cleaning teeth	Twice each 12 consecutive months
	Fluoride applications	Once each 12 consecutive months for Dependents under age 19
	Bite-wing x-rays	Once each 12 consecutive months
		Limited to 4 bitewings
	Full-mouth/ panelipse x-rays	One every 3 years
	Space maintainers	For Dependents under age 14
Basic Dental Care:		
Restorative Services	Amalgam (silver) fillings	For all restorative services repeat treatment is a Covered Benefit 24 months after initial treatment.
	Composite (white) fillings	
	Stainless steel crowns	Limited to baby teeth for dependents under age 14
Oral Surgery	Simple extractions, impactions and other minor surgical procedures	

TYPES OF SERVICES	DESCRIPTION OF BENEFITS	LIMITATIONS
Denture Repair & Recementation of Crowns, Bridges, and Dentures		Cannot exceed ½ the cost of a new denture or prosthesis
Endodontic Services	Root canal therapy	Repeat treatment is a Covered Benefit after 2 years from initial treatment.
Periodontic Services	Scaling and root planing, soft tissue and bony surgery, including grafts	Limitation of 2-3 years apply based on services rendered Periodontal cleaning is considered a regular cleaning and subject to the benefit limitation for regular cleaning.
Major Dental Care:		
Crowns	Single crowns	Once per tooth every 5 years, and only when an existing crown cannot be rendered serviceable. A crown is a Covered Benefit only if the tooth is damaged by decay or fracture to the point that amalgam or composite restoration cannot restore it. Crowns for Dependents under 12 years of age are not covered. Temporary prosthetic devices are not a separate benefit. Any charge for these devices is included in the fee for the permanent device.
Prosthodontics	Partial or complete dentures and fixed bridges	Once every 5 years, and only when an existing prosthesis cannot be rendered serviceable. Fixed Bridges or removable partials are not benefits for Dependents under 16 years of age.

TYPES OF SERVICES	DESCRIPTION OF BENEFITS	LIMITATIONS
Orthodontics:	Removable therapy and comprehensive therapy	

2.1 DEDUCTIBLES, CO-INSURANCES AND BENEFIT MAXIMUMS

Your Deductibles and Co-insurances are listed below. These are your responsibility, not Delta Dental's. The maximum dollar amount that Delta Dental pays for Covered Benefits is also listed below. Amounts over the Benefit Maximums are not Covered Benefits. You pay 100% of the cost of the listed Dental Services for the remainder of the specified benefit period once you reach a Benefit Maximum.

TYPES OF SERVICES	DEDUCTIBLES	CO-INSURANCES	BENEFIT MAXIMUMS
Diagnostic & Preventive Care	None	0%	$1,200 per Covered Person per Contract Year
Basic Dental Care	None	20%	Same as above*
Major Dental Care	None	50%	Same as above*
Orthodontics	None	50%	A separate $1,000 for each Covered Person for the entire period he or she is enrolled with Delta Dental.

* The term "Same as above" used opposite a type of service means that you have an aggregate Deductible or Benefit Maximum for several different types of services. In other words, amounts credited toward your Deductible or Benefit Maximum for one of these services will also be credited toward your Deductible or Benefit Maximum for the type(s) of service(s) listed directly above it. The Deductible is limited to 3 per enrolled family.

3.0 WHO IS ELIGIBLE FOR COVERAGE?

The following people are eligible for coverage. Coverage is subject to the limitations described opposite each coverage category and elsewhere in the Contract. An application is required. An eligible person is only enrolled after Delta Dental receives a signed application and approves it.

COVERAGE CATEGORY	LIMITATIONS
Enrollee	A full-time employee who works 20 or more hours per week and whom the Group determines is eligible for coverage under this EOC and whom, in all cases, Delta Dental accepts as such.
Spouse	The Enrollee's husband or wife whose marriage to the Enrollee is recognized as valid in the jurisdiction in which it occurred and whom Delta Dental accepts as such.
Domestic Partner	A same-sex or opposite sex partner with whom the Subscriber maintains a long-term, committed relationship that is the functional equivalent of marriage and whom Delta Dental accepts as such. Coverage can be extended to dependent children of the domestic partner provided they are the domestic partner's dependent children, as defined by the EOC. In order to qualify as a domestic partner, you and your domestic partner cannot be married to or legally separated from anyone else.
Unmarried children, including stepchildren and adopted children, who are dependent on the Enrollee for support	If full-time students, only to the end of the month they reach age 23 (the "limiting age"). If not full-time students, only to the end of the month they reach age 19 (the "limiting age"). A child of any age who was incapable of self-support due to a severe physical or mental handicap that began before the applicable limiting age specified in this section.

Delta Dental follows United States Internal Revenue Service rules to determine who the Enrollee's Dependent children are. Delta Dental will also follow a court order if the judge directs the Enrollee to cover dental care expenses for a child below the limiting age specified in this section. To qualify as a full-time student, the dependent must be attending a recognized secondary school, trade school, college or university on a full-time basis. The Enrollee must provide proof of full-time student status if Delta Dental requests it. Delta Dental may also require a physician's certification if a child older than the limiting age is not capable of self-support due to a severe physical or mental handicap that began before the limiting age.

Delta Dental will not cover any Dependent child who is on active duty with the armed services. However, Delta Dental will reinstate the Dependent child's coverage; if he or she is otherwise eligible for coverage under the Group's Contract, when the Dependent child is no longer on active duty with the armed services and Delta Dental is notified that the Dependent child is eligible to re-enroll under the Contract. This reinstated coverage will not contain any new pre-existing condition requirement or other similar exclusions or limitations, with one exception. If the pre-existing condition requirement was not satisfied prior to the date the Dependent child's coverage ended because of his or her active duty status, the remainder of his or her waiting period may be applied once the Dependent child returns from active duty and the Group reinstates coverage.

In most cases, the coverage category that the Enrollee selects cannot be changed until the Group's next Annual Enrollment Period. However, an Enrollee may change coverage categories before the Annual Enrollment Period for a Dependent whose coverage status changes due to a qualifying event. Qualifying events are only:

- The Enrollee's marriage, divorce or marriage annulment;
- The birth or adoption of the Enrollee's child;
- The death of the Enrollee's covered spouse or child;
- The Enrollee's spouse adds or drops other dental coverage; or
- The Enrollee's covered child reaches the limiting age specified in this section.

A Dependent will be enrolled on the first day of the month immediately following a qualifying event if the Enrollee notifies Delta Dental in writing no later than 30-days after the qualifying event.

If you are a full-time employee hired after the Effective Date of the Group's coverage, you must enroll when you are first eligible for coverage. Otherwise, you may not enroll until your Group's next Annual Enrollment Period.

Regardless of when you enroll, you may have to serve Benefit Waiting Periods before you receive Covered Benefits. Please refer to the section entitled "What are my dental benefits?" for more information about your Benefit Waiting Periods.

4.0 HOW DO I CHOOSE A DENTIST?

You may select the Dentist of your choice. However, you will receive the highest level of benefits available in your Group's program by choosing a Delta Dental Premier Dentist. In addition, your out-of-pocket costs will usually be lower if you use a Delta Dental Premier Dentist. Please consult Delta Dental's provider directory or visit our website for a list of Delta Dental Premier Dentists. Our website is www.deltadentalva.com. Please provide the Dentist with your Delta Dental identification card on your first visit and later visits if your Dentist requests the card.

5.0 HOW DOES DELTA DENTAL PAY FOR COVERED BENEFITS?

- Covered Benefits by Delta Dental Premier Dentists:

  Our payments are based on Delta Dental Premier Allowances. Delta Dental Premier Dentists have agreed to accept Delta Dental Premier Allowances as payment in full for Covered Benefits. This means that you pay the Deductibles and Co-insurances (if any) for these services. In almost all cases, we pay Delta Dental Premier Dentists directly for Covered Benefits that they provide.

- Covered Benefits by Non-Participating Dentists:

  Our payments are based on Non-Participating Dentist Allowances. Non-Participating Dentists have not agreed to accept Delta Dental Premier Allowances as payment in full for their services. This means

that, in addition to what we pay, you must pay the Deductibles, Co-insurances (if any), and the differences between the Non-Participating Dentists' charges and the Non-Participating Dentist Allowances for Covered Benefits. The amount you would owe a Non-Participating Dentist is typically higher than the amount you would owe a Delta Dental Premier Dentist for the same Covered Benefit. Unless Virginia law requires otherwise, we pay you directly for any Covered Benefits that Non-Participating Dentists provide.

6.0 WHAT HAPPENS IF I HAVE OTHER DENTAL BENEFITS?

If you are covered under this Contract and another Plan or Plans, Delta Dental will coordinate your Covered Benefits in the manner described in this section. Among other things, coordination of benefits eliminates duplicate payments for the same Dental Services.

a. Definitions: The following definitions apply to this coordination of benefits section only:

   (1) Plan: This is any contract issued or administered by Delta Dental or any other Delta Dental plan; dental or health insurance policy, contract or other arrangement in which a dental service benefit is offered or available; a medical or dental HMO; labor management trusteed plan, union welfare plan; employer organization plan; employee benefits plan; or tax-supported or government program to the extent that coordination of benefits is permitted by law. A "Plan" may be insured or self-insured. It may also be an ERISA or a non-ERISA plan. For the purposes of this section only, the term "Plan" does not mean an individually underwritten and issued policy, contract or other arrangement that provides for accident and sickness benefits exclusively and for which the patient, patient's guardian, or family member pays the entire premium.

   (2) Primary Plan: This is the Plan responsible for determining and paying benefits first.

   (3) Secondary Plan: This is the Plan or Plans responsible for determining and paying benefits after the Primary Plan determines and pays its benefits.

b. Order of Benefits Determination: If a Covered Person is covered under this Contract and any other Plan or Plans, Delta Dental will

use the following rules to determine which Plan is the Primary Plan and which Plan is the Secondary Plan:

- Your medical benefits Plan may provide coverage for a few Dental Services that Delta Dental also covers. In this case, your medical benefit Plan is always the Primary Plan. Extraction of impacted wisdom teeth and oral surgery are examples of services sometimes covered under both medical benefits Plans and dental benefits Plans.

- If the other Plan does not have a coordination of benefits provision similar to this one, the other Plan is the Primary Plan.

- If both or all Plans have coordination of benefits provisions that are similar, Delta Dental will use the following rules, in the order listed, to determine which Plan is the Primary Plan:

  (1) The Plan that covers the patient as an Enrollee is the Primary Plan. The Plan that covers the patient as a Dependent is the Secondary Plan.

  (2) For patients who are dependent children whose parents are neither divorced nor separated, the Primary Plan is the Plan of the parent whose birthday falls earlier in the calendar year. Only the month and day are considered. In the unlikely event that both parents have the same birthday (month and day only), the Plan that covered the parent longer will be the Primary Plan. Also, the father's Plan is the Primary Plan if one Plan has a rule based on the parent's gender and, because of this "gender rule", the Plans' rules differ on which parent's Plan is the Primary Plan.

  (3) When a court order establishes that a divorced or separated parent has financial responsibility for a dependent child's dental care expenses, that parent's Plan is the Primary Plan for that dependent child.

  (4) In the absence of a court order, the following coordination of benefits rules apply to dependent children of divorced or separated parents:

    (a) Until one parent re-marries, the Plan of the parent with legal custody is the Primary Plan.

(b) After one parent re-marries or both parents re-marry, the Plan of the parent with legal custody is the Primary Plan. The Plan of the child's custodial stepparent is the Secondary Plan. Plan benefits for the child's parent without legal custody are determined third. The non-custodial stepparent's Plan benefits are determined fourth.

(5) The Plan that covers the patient as a working employee (or dependent of a working employee) is the Primary Plan. The Plan that covers the patient as a former or retired employee (or his or her dependent) is the Secondary Plan.

(6) When none of the other rules apply, the Plan that has covered the patient for the longest uninterrupted period of time is the Primary Plan.

c. This Contract is the Primary Plan if both the rules listed in paragraph b. of this coordination of benefits section and the other Plan's coordination of benefits rules require the benefits under this Contract to be determined first. As the Primary Plan, this Contract's benefits are determined as though the other Plan did not exist. In all other cases, this Contract is the Secondary Plan. As the Secondary Plan, this Contract's benefits will be coordinated so that the sum of all benefits payable by all of the Plans (including this Plan) does not exceed what Delta Dental would have paid in the absence of this coordination of benefits section. For example, when Delta Dental is the Secondary Plan, Delta Dental's obligation to provide Covered Benefits under this Contract will be deemed satisfied if the Primary Plan owes the same amount that Delta Dental would have owed if benefits had not been coordinated. In addition, if Delta Dental is the Secondary Plan, Delta Dental's obligation to provide Covered Benefits for Dental Services under this Contract will be deemed satisfied if Delta Dental pays less for Covered Benefits than it would have paid as the Primary Plan. Another Plan's benefits may be coordinated even though a claim was not filed with that other Plan.

d. Your Covered Benefits will not increase because benefits are coordinated. Delta Dental will never pay more than it would have paid in the absence of this section. When benefits are provided in the form of services, Delta Dental assigns reasonable cash values to those services. If your Primary Plan is a medical or dental HMO that pays your Dentist on a capitated basis, Delta Dental's only obligation as the Secondary Plan is your deductible or co-payment for the HMO

coverage, if any. If your Dentist has an agreement with the Primary Plan to accept a lower allowance than Delta Dental's allowance as payment in full for a Covered Benefit, Delta Dental coordinates benefits using the Primary Plan's allowance rather than Delta Dental's allowance.

e. Delta Dental only coordinates benefits after it receives information about other Plan(s). Delta Dental cannot determine whether you have other coverage without your help. You should provide Delta Dental with all information about coverage available from the other Plan(s). By accepting coverage under this Plan, you authorize Delta Dental to obtain from, and release to, any other Plan all of the information necessary to coordinate benefits. You also authorize Delta Dental to recover from any other Plan, your Dentist, or you the amount of Covered Benefits that Delta Dental has paid in excess of its obligations under this coordination of benefits section. Delta Dental determines whether another Plan should be reimbursed for benefits to which the other Plan may be entitled as the Secondary Plan.

7.0 DOES DELTA DENTAL REVIEW CLAIMS IN ADVANCE?

Delta Dental reviews some claims in advance. If Dental Services for a single procedure or series of related procedures are expected to cost more than $250, your Dentist may submit a Predetermination Plan to Delta Dental before he or she provides the services. We will notify your Dentist and you whether the Dental Services described in the Predetermination Plan are Covered Benefits and how much Delta Dental will pay. With this information, your Dentist can better discuss treatment options and costs with you, if necessary.

A procedure that Delta Dental determines is a Covered Benefit on the basis of its review of the Predetermination Plan will be a Covered Benefit when your claim is submitted only if: (1) the procedure performed is the same as that reviewed as part of the Predetermination Plan; and (2) the other terms, conditions, and limitations of the Contract are satisfied. Without Delta Dental's express written consent, the authorized period within which treatment must begin will not extend beyond 60 days from the last day of the month in which Delta Dental receives the Predetermination Plan. Except as provided in the section entitled "What other payment rules effect my coverage", the authorized period of treatment will not extend beyond the date on which your coverage under the Contract ends.

8.0 HOW AND WHEN DO I FILE CLAIMS?

In most cases, your Dentist will file claims for you. If your Dentist does not, you may file the claim yourself. To obtain a claim form, please contact a Delta Dental customer service representative at **(800) 237-6060**. Claim forms are also available on our website at www.deltadentalva.com. All claims should be submitted promptly after services are completed. However, there are timely filing limitations. In all cases, a claim for Covered Benefits will only be paid if it is filed with Delta Dental within one (1) year after (1) the date on which the service is performed, or (2) if a series of related services is performed, the last day on which the last service in the series is performed. Delta Dental will not pay a claim that is submitted after the end of these timely filing periods.

9.0 WHAT HAPPENS IF MY CLAIM IS DENIED OR I WANT TO FILE A COMPLAINT?

The following is a description of how the Plan processes a claim for benefits. A claim is defined as any request for a Plan benefit, made by you or by your representative that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period begins at the time the Claim is filed. "Days" means calendar days.

There are different types of claims and each one has a specific timetable for either approval of the claim, a request for more information to process the claim, or denial of the claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

A. Claims Review and Appeals Procedures

Under the Employee Retirement Income Security Act (ERISA) of 1974, you have the right to appeal a denied claim. The claim procedures and appeal process for health care plans are as follows:

Claims Review Chart		
Type of Claim		**Claim Procedures and Appeal Process**
Post-Service Health Claim		
Claim that is a request for payment under the Plan for covered services already received.	**Step 1:**	The plan has **30 days** after receiving your **initial claim** to notify you if your claim is approved or denied. The plan is permitted a one time extension of **15 days** for matters beyond the control of the plan. You must be notified within the initial 30 day period by the plan of the extension and the reason for the extension.
	Step 2:	You have **180 days** after receiving the claim denial to appeal the plan's decision.
	Step 3:	The plan has **60 days** after receiving your appeal (30 days if the plan allows two (2) levels of appeal) to notify you of the appeal decision. Both levels of appeal must be completed within the 60 day deadline.
If Your Claim is Improper or Incomplete		
	Step 1:	The plan has **30 days** after receiving your claim to notify you of its decision to approve or deny the claim. The plan is permitted a one time extension of **15 days** due to insufficient information received with the claim and the plan is unable to make a benefit determination. The plan must notify you within **15 days** after receipt of the initial claim if an extension will be needed.
	Step 2:	You have **45 days** after receiving the extension notice to provide additional information or complete the claim.
	Step 3:	If your claim is denied, you have **180 days** after receiving the claim denial to appeal the plan's decision.
	Step 4:	The plan has **60 days** after receiving your appeal (**30 days** if the plan allows two (2) levels of appeal) to notify you of the appeal decision. Both levels of appeal must be completed within the 60 day deadline.

B. Decisions on Appeals

Service representatives are available during regular business hours to answer your questions. Our telephone number is **(800) 237-6060**. If a matter cannot be resolved to your satisfaction based on a telephone call, Delta Dental's internal appeals process is available to you. This is a mandatory process. This means that you must use Delta Dental's internal appeals process before taking any legal action. You must file your appeal within **180 days** after you receive our notice of denial.

The maximum number of appeals permitted under an ERISA benefit plan is two (2); however, in some cases there may be additional voluntary appeal options available to you. Delta Dental has a one level appeal process; therefore, you will need to verify with your Plan Administrator the number of appeals offered by the Plan and if a voluntary appeal is offered.

If your Plan has a second appeal level or a voluntary appeal option available, you will need to file this appeal directly with the Plan administrator. Under ERISA, the Plan administrator's Benefits Appeal Committee has the authority to make final decisions with respect to paying claims under this plan. In making a final decision, the Benefits Appeal Committee has sole, absolute and discretionary authority, which shall be final and binding on Covered Persons and all other parties to the maximum extent allowed by law in interpreting the meaning of the Plan provisions and in determining all questions arising under the Plan, including, but not limited to, eligibility for benefits.

You must file the appeal in writing and explain why you believe our initial decision was incorrect. Your appeal should include the following information: your name, address, and daytime telephone number; the Enrollee's member number (usually the Enrollee's social security number); the patient's name; the date of service; and the name and address of the Dentist who provided the service. You may submit written comments, documents, records, and other information relating to the claim for benefits, even though the information was not considered when the initial decision was made. You may request, and we will provide to you free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

We will conduct the appeal without deferring to the original adverse decision. The individual who conducts the appeal will not be the person who made the initial decision or that person's subordinate. We will consult a dental care professional who has appropriate training and experience in the field of dentistry involved if dental judgment is required. The dental care

professional with whom we consult for the appeal will not be the person with whom we consulted in making the initial decision or that person's subordinate. Upon request, we will identify the dental professional whom we consulted, whether or not we relied on his or her advice in reaching our adverse decision.

Please send your request for reconsideration to:

Delta Dental of Virginia
Attn: Appeals
4818 Starkey Road
Roanoke, Virginia 24018

You may also file a complaint with Delta Dental at any time if you are dissatisfied in any manner with your coverage, the quality of care, the choice and accessibility of dentists, the adequacy of our network, or with any other aspect of our program. Your Dentist may also file a complaint on your behalf. Delta Dental's process and timeframes for responding to and resolving complaints are the same as those for its internal appeals process.

C. Notice to Claimant of Adverse Benefit Determinations

Except with urgent care claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination.

The notice will contain:

1. The specific reason(s) for the adverse benefit decision;

2. A reference to the specific plan provision(s) on which the decision is based;

3. A description of the additional information we may require to decide if the claim is covered and an explanation why that information is necessary; and

4. A description of the plan's review or appeal procedures and time frames, and notice that you may bring a civil action under the appropriate section of ERISA, if applicable.

The following information will be provided, free of charge and upon request by you or your authorized representative:

1. A copy of any internal rule, guideline, protocol or similar criterion on which we relied in making our decision;

2. An explanation of the scientific or clinical basis on which we based our decision about dental necessity, necessary and customary treatment, and "valid need" limitations. In this explanation, we will apply the group dental plan's terms to your dental circumstances.

D. Authorized Representative

You may authorize a representative to act on your behalf in pursuing a claims review or claims appeal. We may require that you identify your authorized representative for us in writing in advance. For an urgent care claim, you may designate a dental care professional, who is knowledgeable about your dental condition, to act on your behalf. We will deal directly with your authorized representative, rather than you, for matters involving the claim or appeal.

E. External Appeal

If, at the end of Delta Dental's internal appeal process, you are dissatisfied with the outcome, there is an external review process available for certain adverse utilization review decisions. This process is limited to claims denials for dental necessity and similar reasons. The Virginia Bureau of Insurance administers this program. You must appeal Delta Dental's final adverse decision to the Virginia Bureau of Insurance within 30 days after that decision. Also, to use the external review process, the Covered Person's actual costs for the dental service must exceed $300 if the final adverse decision is not reversed.

The "Office of Managed Care Ombudsman" is part of the Virginia Bureau of Insurance. One of the primary reasons that this office exists is to help Virginia consumers understand and exercise their rights to appeal some adverse claims decisions. **If you have any question about an appeal or grievance involving a Dental Service that you have been provided and which Delta Dental has not satisfactorily addressed, you may contact the Office of Managed Care Ombudsman for assistance.** You may contact the office in any of the following ways:

Address:	**Office of Managed Care Ombudsman** **Virginia Bureau of Insurance** **P.O. Box 1157** **Richmond, Virginia 23218**
Telephone Toll-Free:	**(877) 310-6560**
Richmond Metropolitan Area:	**(804) 371-9032**
E-Mail:	**ombudsman@scc.state.va.us**
Web Page:	**http://www.state.va.us/scc**

There are two other units of state agencies that will assist you with appeals and complaints. In most cases, you must complete Delta Dental's internal appeal or complaint processes first.

- For help with quality of care issues, you may contact the complaint unit of the Virginia Department of Health's Center for Quality Health Care Services and Consumer Protection. The Center's address is 3600 West Broad Street, Suite 216; Richmond, Virginia 23230-4920. The Complaint Unit's telephone number is (800) 955-1819.

- You may also contact the Consumer Complaint Section of the Virginia Bureau of Insurance. The Section's address is Virginia State Corporation Commission; Bureau of Insurance; Life and Health Division; Consumer Complaint Section; P.O. Box 1157; Richmond, Virginia 23218. The Consumer Complaint Section's telephone number is (800) 552-7945.

10.0 WHAT HAPPENS WHEN MY COVERAGE ENDS?

Your coverage ends on the last day of the month that you are no longer eligible under the Contract. If you are a Group employee, this may be the last day of the month that your employment ends. If you are a Dependent, this may be the last day of the month the Subscriber's coverage ends or you reach the limiting age for coverage. Except as otherwise provided in this EOC, all Covered Persons' coverage will end when the Group Contract ends. For further information, please see the section entitled "Who is eligible for coverage." Until the Group Contract ends, you may continue coverage with Delta Dental for the following limited period of time:

You may continue coverage under an individual dental care policy. Benefits under an individual conversion dental care policy may not match

your current benefits under your Group's dental care policy. The individual policy will be issued without further evidence of insurability, subject to the following:

1. You apply for the policy and pay the first premium to Delta Dental within 31 days after your Group coverage ends;

2. The premium for the policy will be at Delta Dental's then customary rate for these policies;

3. The policy does not result in over-insurance in the basis of Delta Dental's underwriting standards at the time of issue;

4. The benefits under the policy do not duplicate any benefits paid for the same dental service under the prior policy;

5. The policy will extend coverage to the same family members that were insured under the prior Group policy; and

6. Coverage under the individual policy will be provided in such a way that you will have continuous coverage during the 31-day period within which you must make application and pay the first premium.

After you cease to be eligible for Group coverage and your Group is subject to the federal "COBRA" law, you may be eligible for COBRA continuation coverage. Your Group administrator can provide more details about Group continuation options and COBRA continuation. In all cases, the person continuing the coverage, not the Group, is responsible for paying premiums.

11.0 WHAT OTHER PAYMENT RULES AFFECT MY COVERAGE?

- In this program, if you are responsible for both a Deductible and Co-insurance, Delta Dental determines its payment amount by (1) first, subtracting your Deductible from the amount that Delta Dental would allow in the absence of the Deductible and Co-insurance and (2) then, multiplying the remainder by the payment percentage for which Delta Dental is responsible. The payment percentage for which Delta Dental is responsible is the difference between 100% and the Co-insurance percentage for which you are responsible.
- After consulting with your Dentist, you may select a more expensive Covered Benefit than the one that Delta Dental determines is

necessary or customary for the diagnosis or treatment of your condition. However, Delta Dental will only pay the amount that it would have paid for the less expensive Covered Benefit. In most cases, Delta Dental's payment for the more expensive service will not exceed what Delta Dental customarily pays to restore your tooth to its proper contour and function. You are responsible for the entire balance of the Dentist's fee for the more expensive Covered Benefit.

- Some Dental Services cannot be completed in one visit to the Dentist's office. Examples include crowns, bridges, removable prosthetics, and endodontic services. Delta Dental only pays for Covered Benefits that require multiple visits after the entire course of treatment is completed. Your date of service is the final completion date for all these services. You are responsible for the Dentist's full charges for Dental Services requiring multiple visits if you or your Dentist (1) does not complete the entire course of treatment or (2) changes the type of dental treatment before your last visit.

- If a course of treatment is interrupted and later resumed by another Dentist, Delta Dental will apportion its payment for all Covered Benefits provided during that course of treatment between the Dentists. Delta Dental will apportion its payment in the manner that it determines is reasonable and equitable to both Dentists. How much is apportioned between the Dentists is a matter within Delta Dental's sole discretion. You may be responsible for any unpaid balances if the Dentists do not agree.

- As a general rule, Dental Services started before the Effective Date of your coverage under this Contract are not covered. Examples of these type services include, but are not limited to:

  (1) Fixed bridgework and a full or partial denture, but only if the Dentist took first impressions or fully prepared the abutment teeth before the Effective Date of your coverage under this EOC; and

  (2) A crown but only if the Dentist fully prepared your tooth before the Effective Date of your coverage under this EOC; and

  (3) Root canal therapy, but only if the Dentist opened the pulp chamber of your tooth before the Effective Date of your coverage under this EOC.

Without exception, to be covered under this Contract, the services listed in this paragraph must also be listed as Covered Benefits in the section of this EOC entitled “What are my dental benefits.”

- As a general rule, a Dental Service is not covered if you receive the service after your coverage under this Contract ends. However, there are exceptions for Dental Services that require multiple visits to the Dentist’s office. The only exceptions to this general rule are:

  (1) Fixed bridgework and a full or partial denture, but only if (a) the Dentist takes first impressions or fully prepares the abutment teeth before the date your coverage under this EOC ends and (b) your bridgework or denture is delivered or installed within 30-days after that date;

  (2) A crown but only if (a) the Dentist fully prepares the tooth to be treated before the date your coverage under this EOC ends and (b) your crown is installed within 30-days after that date; and

  (3) Root canal therapy, but only if the Dentist (a) opens the pulp chamber of your tooth before the date your coverage under this EOC ends and (b) your treatment is completed within 30-days after that date.

  Without exception, to be covered under this Contract, the services listed in this paragraph must also be listed as Covered Benefits in the section of this EOC entitled “What are my dental benefits.”

- Delta Dental makes periodic payments for covered orthodontic services, up to the Benefit Maximum, over the entire course of treatment. Except as otherwise explained in this paragraph, Delta Dental pays part of its total allowance for the banding portion of the orthodontic service. Delta Dental pays the balance of its total allowance over the remainder of the treatment period. If your course of orthodontic treatment begins before your Effective Date under this EOC, Delta Dental reduces its total allowance by the amount that any prior dental service carrier or self-insured plan has paid or was obligated to pay on your behalf. If your coverage under this EOC ends during your course of orthodontic treatment, Delta Dental covers the banding portion of the service only if the bands are installed prior to the date your coverage ends. In addition, if your coverage under this EOC ends during your course of treatment, Delta Dental covers follow-up visits to the orthodontist only if you are enrolled on the first day of the month in which the visit takes place.

12.0 WHAT IS EXCLUDED?

Delta Dental will not, under any circumstances, cover any of the following:

- Services or supplies that are not Dental Services; also services not specifically listed as covered in this EOC or on Delta Dental's covered procedure code list for your Group's program.

- Services or treatment provided by someone other than a Dentist or a qualified dental hygienist working under the supervision of a Dentist.

- Services or treatment provided by a Non-Participating Dentist that would not be covered if provided by a Delta Dental Premier Dentist.

- A Dental Service that Delta Dental, in its sole discretion, determines is not necessary or customary for the diagnosis or treatment of your condition. In making this determination, Delta Dental will take into account generally accepted dental practice standards in the area in which the Dental Service is provided. In addition, a Covered Person must have a valid need for each Covered Benefit. A "valid need" is determined in accordance with generally accepted standards of dentistry.

- Dental Services for injuries or conditions that may be covered under workers compensation or similar employer liability laws; also benefits or services that are available under any federal or state government program (subject to the rules and regulations of those programs) or from any charitable foundation or similar entity.

- Dental Services for the diagnosis or treatment for illnesses, injuries or other conditions for which you are eligible for coverage under your hospital, medical/surgical, or major medical plan.

- Except as otherwise provided for in this EOC, Dental Services started or rendered before the date the Covered Person is enrolled under the EOC. Also, except as otherwise provided in this EOC, benefits for a course of treatment that began before the Covered Person is enrolled under this EOC.

- Except as otherwise provided in this EOC, Dental Services provided after the date that the individual is no longer enrolled or eligible for coverage under the EOC.

- Prescription and non-prescription drugs; pre-medications; preventive control programs, oral hygiene instructions, and relative analgesia.

- When less than three (3) teeth will be extracted during the same office visit, general anesthesia is not a Covered Benefit.

- Splinting or devices used to support, protect, or immobilize oral structures that have loosened or been reimplanted, fractured or traumatized.

- Charges for inpatient or outpatient hospital services; any additional fee that the Dentist may charge for treating a patient in a hospital, nursing home or similar facility.

- Charges to complete a claim form, copy records, or respond to Delta Dental's requests for information; charges for failure to keep a scheduled appointment.

- Charges for telephone consultations or consultations by other electronic means.

- Dental Services excluded by rules and regulations adopted by Delta Dental's Board of Directors, including Delta Dental's standard processing policies.

- Dental Services to the extent that benefits are provided or would have been provided if the Covered Person had enrolled, applied for, or maintained eligibility under Title XVIII of the Social Security Act (Medicare), including any amendments or other changes to that Act.

- Complimentary services or Dental Services for which the Covered Person would not be obligated to pay in the absence of the coverage under this EOC or any similar coverage.

- Services or treatment provided to an immediate family member by the treating Dentist. This would include a Dentist's parent, spouse or child.

- Dental Services and supplies for the replacement device or repeat treatment of lost, misplaced or stolen prosthetic devices including space maintainers, bridges and dentures (among other devices) unless the device and/or treatment is listed as covered in a section of this EOC entitled "What are my dental benefits?".

- Dental Services or other services that Delta Dental determines are for the purpose of correcting congenital malformations; also, cosmetic surgery or dentistry for cosmetic purposes.

- Unless otherwise provided in this EOC, we will not cover experimental or investigative dental procedures, services, supplies as well as services and/or procedures due to complications thereof. Experimental or investigative procedures, services or supplies are those which, in the judgment of the Delta Dental: (a) are in a trial stage; (b) are not in accordance with generally accepted standards of dental practice, or (c) have not yet been shown to be consistently effective for the diagnosis or treatment of the Covered Person's condition.

- Dental Services for increasing vertical dimension, restoring occlusion, replacing tooth structure lost by attrition, correcting developmental malformations or for esthetic purposes.

- Dental Services, procedures and supplies that are needed as a result of a Covered Person's harmful habits. An example of a harmful habit includes grinding of the teeth.

- Services billed under multiple Dental Service procedure codes that Delta Dental, in its sole discretion, determines should have been billed under a single, more comprehensive Dental Service procedure code. Delta Dental's payment is based on the allowance for the more comprehensive code, not on the allowances for the underlying component codes.

- Services billed under a Dental Service procedure code that Delta Dental, in its sole discretion, determines should have been billed under a code that more accurately describes the Dental Service. Delta Dental's payment is based on its determination of the more accurate Dental Service code.

- Dental Services that are not for the treatment of natural teeth or supporting structure.

- Supplies and services relating to vertical bitewings.

- Use of dental implants or implantology techniques. Placing or removing implants and services associated with implants including, without limitation, cleaning or periodontal treatment.

- Therapy and appliances to correct temporomandibular joint (TMJ) syndromes, problems and/or occlusal disharmony (including occlusal equilibration).

- Amounts that exceed the DeltaPremier Allowances for Covered Benefits.

13.0 WHICH TERMS HAVE SPECIAL MEANINGS?

This is the definitions section. The following terms used in the Contract, including this EOC, have these meanings:

- Annual Enrollment Period: The period of time designated by the Group for employees to elect coverage for the upcoming Contract Year.

- Benefit Maximum: This is the total dollar amount that Delta Dental will pay for the listed Covered Benefits during the specified benefit period.

- Calendar Year: This is the period from January 1st through (1) December 31st or (2) the date the coverage under this EOC ends if it ends earlier.

- Contract: This means the Group's Dental Care Contract, including this EOC and other EOCs, schedules, addenda, and amendments that are made a part of the Group's Dental Care Contract.

- Contract Year: This is the twelve consecutive month period beginning on the Effective Date of this EOC and each twelve consecutive month period after that until the date the coverage under this EOC ends.

- Co-insurance: This is a fixed percentage of the cost of Covered Benefits. It reduces the amount Delta Dental would otherwise pay for Covered Benefits. A Covered Person pays the Co-insurance to the Dentist, not to Delta Dental.

- Covered Benefits: This means the Dental Services covered under this EOC subject to its terms, conditions, exclusions, and limitations.

- Covered Person: This is another name for the Enrollee. It also means the Enrollee's Dependents who are entitled to coverage and validly enrolled under this EOC.

- Deductible: This is a fixed dollar amount. It reduces the amount that Delta Dental would otherwise pay for Covered Benefits. The Covered Person pays the Deductible to the Dentist, not to Delta Dental.

- Delta Dental: This means Delta Dental of Virginia.

- Delta Dental Premier Allowance: For each Covered Benefit, this means the lowest of (1) the fee that the Dentist bills Delta Dental, (2) the most recent fee for the service the Dentist has on file with Delta Dental, or (3) the allowance that the Dentist has agreed to accept as full payment (plus deductibles and Co-insurances, if any) for the Covered Benefit that he or she provides to a Covered Person in a Delta Dental Premier program. In all cases, Delta Dental determines the Delta Dental Premier Allowance.

- Delta Dental Premier Dentist: This is a Dentist who has a Delta Dental Premier Dentist agreement with the Participating Plan (including Delta Dental) in the state or other jurisdiction in which the service is provided. This agreement must be in effect on the date the service is provided.

- Dental Services: This means care and procedures provided by a Dentist for the diagnosis and treatment of dental disease or injury. Not all Dental Services are Covered Benefits.

- Dentist: This means a person with a valid, unrestricted license to practice dentistry in the state in which the Dental Service is provided.

- Dependent: This is the Enrollee's spouse or domestic partner and unmarried dependent child who is properly enrolled under this EOC. A Dependent's eligibility is subject to the limitations described in the EOC section entitled "Who is eligible for coverage."}

- Effective Date: This is the date that you become entitled to benefits and are properly enrolled under your Group's Contract.

- Enrollee: This is a person who satisfies the eligibility criteria for a "Covered Person" in the EOC section entitled "Who is eligible for coverage" and who is properly enrolled under this EOC.

- Evidence of Coverage or EOC: This means this booklet and any amendments, riders, or endorsements to this booklet that Delta Dental issues. This booklet is part of your Group's Contract.

- Group: This means the Enrollee's employer or other enrolling entity identified on the first page of the Contract.

- Non-Participating Dentist: This is a Dentist who does **not** have a Delta Dental Premier Dentist agreement in effect on the date your Dental Services are provided. You typically pay more out-of-pocket if you select a Non-Participating Dentist to provide Covered Benefits.

- Non-Participating Dentist Allowance: For each Covered Benefit, this means the lower of (1) the fee that the Dentist bills Delta Dental or (2) the payment allowance that the Participating Plan (including Delta Dental) has set for the Covered Benefit that the Non-Participating Dentist provides. This allowance may be lower than the Delta Dental Premier Allowance for the same Covered Benefit. In all cases, Delta Dental determines the Non-Participating Dentist Allowance.

- Participating Plan: This means any Delta Dental member company (including Delta Dental) that has entered into a "DeltaUSA Interplan Participating Agreement" that is in effect at the time services are rendered.

- Predetermination Plan: This is a detailed description of Dental Services that your Dentist prepares and Delta Dental reviews, before these Dental Services are provided, to determine which Dental Services are Covered Benefits.

- We, Us, or Our: This refers to Delta Dental of Virginia.

- You, Your, or I: This refers to the Covered Person.

Notes