Delta Dental of Delaware

State of Delaware

Combined Evidence of Coverage and Disclosure Form

deltadentalins.com

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Delta Dental
Administrative Offices
One Delta Drive
Mechanicsburg, PA 17055-6999
(717) 766-8500 Toll free: (800) 932-0783
TTY/TDD: (888) 373-3582
www.deltadentalins.com

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INTRODUCTION

Delta Dental is pleased to welcome you to the group dental plan for State of Delaware. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the dentist, but to see him/her on a regular basis.

Using This Evidence of Coverage

This Evidence of Coverage discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the plan works and how to obtain dental care. Please read this booklet completely and carefully. Keep in mind that YOU and YOUR mean the individuals who are covered. WE, US and OUR always refer to Delta Dental. In addition, please read the **Definition of Terms** section, which will explain any words that have special or technical meanings under the plan.

The benefit explanations contained in this booklet are subject to all provisions of the Group Dental Service Contract on file with your employer, trust fund, or other entity ("Plan Administrator") and do not modify the terms and conditions of that contract in any way, nor shall you accrue any rights because of any statement in or omission from this booklet.

Contact Us

If you have any questions about your coverage that are not answered here, please visit our web site at www.WeKeepYouSmiling.com/State of Delaware or call our Customer Service Center. A Customer Service Center representative can answer questions you may have about obtaining dental care, help you locate a participating dentist, explain benefits, check the status of a claim, and assist you in filing a claim.

Representatives are available by telephone Monday through Friday, 8:00 a.m. to 8:00 p.m. Eastern Time at (717) 766-8500 or toll-free at (800) 873-4165. If you are hearing impaired, you may call our toll-free TTY/TDD number at (888) 373-3582. You can also access Delta Dental's automated information line at (800) 932-0783 to obtain information about Member eligibility and benefits, group benefits, or claim status.

If you prefer to write Delta Dental with your question(s), please mail your inquiry to the following address:

Delta Dental
One Delta Drive
Mechanicsburg, PA 17055

SELECTING YOUR DENTIST

Free Choice of Dentist

Delta Dental recognizes that many factors affect the choice of dentist and therefore supports your right to freedom of choice regarding your dentist. This assures that you have full access to the dental treatment you need from the dental office of your choice. You may see any licensed dentist for your covered treatment:

- Delta Dental PPO Participating Dentist ("PPO")
- Delta Dental Premier Participating Dentist ("Premier")
- Non-Participating Dentist

In addition, you may choose your own specialist, and you and your family members can see different dentists.

Remember, you enjoy the greatest savings when you choose a PPO Dentist. To take full advantage of your benefits, we highly recommend you verify a dentist's participation status within a Delta Dental network with your dental office before each appointment. Review the section titled "How Claims Are Paid" for an explanation of Delta Dental payment procedures to understand the method of payments applicable to your dentist selection and how that may impact your out-of-pocket costs.

Referrals to Specialists

Your dentist may refer you to another dentist for a consultation or specialized treatment or you may elect to see a specialist on your own. If this is done, be sure that the dentist you are referred to is a participating dentist. You can do this by simply asking the specialist when you make your appointment. Visiting a dentist who has agreed to participate in the Delta Dental network can save you money, time, and the hassle of paperwork. Remember, if the dentist is not a participating dentist, you may be required to pay all of the treatment cost at the time of service and submit a claim to Delta Dental for reimbursement.

Locating a Delta Dental Participating Dentist

There are several ways in which you can locate a participating dentist near you:

- You may access information about the plan through our web site at www.WeKeepYouSmiling.com/State of Delaware. This web site includes a dentist search function allowing you to locate Delta Dental participating dentists by location, specialty and network type; or

- You may also call Delta Dental and one of our representatives will assist you. He/she can provide you with information regarding a dentist's membership status, specialty and office location.

PLAN INFORMATION

Benefit Summary Charts

The services provided through the plan include all the benefits described in the Benefit Summary Charts on the following pages, depending on the participation status of the dentist providing the services, with the exception of those items presented in the **Limitations and Exclusions** section. The plan covers several categories of benefits when a licensed dentist provides the services and when they are within the standards of generally accepted dental practice. To help you understand the types of procedures that are included in each of the categories of services, examples and descriptions are provided in the charts. The Member's share may be higher than the percentages listed in the charts, depending on the applicability of deductibles, maximums, the difference between the non-participating dentist's fee and the Non-participating Dentist Maximum Plan Allowance or charges for non-covered services.

The information in the following chart applies to services provided by Delta Dental PPO Dentists only.

Benefit Summary Chart

Category of Service	Paid by Delta Dental	Paid By Member
Diagnostic (deductible waived)	100%*	0%
Periodic exams (twice per contract year)		
Bitewing x-rays (twice per contract year)		
Full-mouth x-ray (once per 3-year period)		
See note on additional benefits during pregnancy		
Preventive (deductible waived)	100%*	0%
Routine prophylaxis (cleaning) (twice per contract year)		
Fluoride treatments (twice per contract year to age 19)		
Sealants (to age 16)		
Space maintainers (to age 19)		
See note on additional benefits during pregnancy		
Basic Restorative	80%*	20%
Fillings (amalgam "silver" and composite "white" non-molar)		
Major Restorative	50%*	50%
Single crowns, inlays, onlays		
Oral Surgery	50%*	50%
Extraction and other oral surgery procedures, incl. pre- and post-operative care		
Endodontics	80%*	20%
Root canal, pulpal therapy		
Surgical Periodontics	50%*	50%
Surgical treatment of the gums and supporting structures of the teeth		
Non-Surgical Periodontics	80%*	20%
Non-surgical treatment of the gums and supporting structures of the teeth		
See note on additional benefits during pregnancy		
Prosthodontics	50%*	50%
Procedures for replacement of missing teeth by construction of bridges and partial or complete dentures		
Orthodontics (deductible waived)	50%*	50%
For eligible employees, spouses and dependents to age 26		
General Anesthesia	50%*	50%
Covered when used in conjunction with covered oral surgical procedures		
Bridge Repair	80%*	20%
Crown/Inlay/Onlay Repair	80%*	20%
Denture Repair	80%*	20%
Periodontal Maintenance	80%*	20%
Periodontal prophylaxis (twice per contract year)		
Simple Extractions	80%*	20%

	Deductibles	Maximums
Individual (Contract year)	$ 50.00	$1,500.00
Family (Contract year)	$150.00	$n/a
Orthodontics (Lifetime)	$ 50.00	$1,000.00

***For Delta Dental PPO Dentists, percentages are based on the PPO Allowed Amount, which is the lesser of the dentist's submitted fee or the PPO Maximum Plan Allowance.**

The information in the following chart applies to services provided by Delta Dental Premier Dentists and Non-Participating Dentists only.

Benefit Summary Chart

Category of Service	Paid by Delta Dental	Paid By Member
Diagnostic (deductible waived)	80%*	20%
Periodic exams (twice per contract year)		
Bitewing x-rays (twice per contract year)		
Full-mouth x-ray (once per 3-year period)		
See note on additional benefits during pregnancy		
Preventive (deductible waived)	80%*	20%
Routine prophylaxis (cleaning) (twice per contract year)		
Fluoride treatments (twice per contract year to age 19)		
Sealants (to age 16)		
Space maintainers (to age 19)		
See note on additional benefits during pregnancy		
Basic Restorative	80%*	20%
Fillings (amalgam "silver" and composite "white" non-molar)		
Major Restorative	50%*	50%
Single crowns, inlays, onlays		
Oral Surgery	50%*	50%
Extraction and other oral surgery procedures, incl. pre- and post-operative care		
Endodontics	80%*	20%
Root canal, pulpal therapy		
Surgical Periodontics	50%*	50%
Surgical treatment of the gums and supporting structures of the teeth		
Non-Surgical Periodontics	80%*	20%
Non-surgical treatment of the gums and supporting structures of the teeth		
See note on additional benefits during pregnancy		
Prosthodontics	50%*	50%
Procedures for replacement of missing teeth by construction of bridges and partial or complete dentures		
Orthodontics (deductible waived)	50%*	50%
For eligible employees, spouses and dependents to age 26		
General Anesthesia	50%*	50%
Covered when used in conjunction with covered oral surgical procedures		
Bridge Repair	80%*	20%
Crown/Inlay/Onlay Repair	80%*	20%
Denture Repair	80%*	20%
Periodontal Maintenance	80%*	20%
Periodontal prophylaxis (twice per contract year)		
Simple Extractions	80%*	20%

	Deductibles	**Maximums**
Individual (Contract year)	$ 50.00	$1,500.00
Family (Contract year)	$150.00	$n/a
Orthodontics (Lifetime)	$ 50.00	$1,000.00

***For Delta Dental Premier Dentists, percentages are based on the Premier Allowed Amount, which is the lesser of the dentist's submitted fee or the Premier Maximum Plan Allowance. For Non-participating Dentists, percentages are based on the Non-participating Dentist Allowed Amount, which is the lesser of the dentist's submitted fee or the Non-participating Dentist Maximum Plan Allowance.**

Copayments

The plan will pay a percentage of the applicable allowed amount (PPO Allowed Amount for PPO Dentists, Premier Allowed Amount for Premier Dentists and Non-Participating Dentists Allowed Amount for Non-participating Dentists) for each covered service, subject to certain limitations, and you are responsible for paying the balance. What you pay is called the copayment and is part of your out-of-pocket cost. You pay this even after a deductible has been met.

The amount of your copayment will depend on the type of service provided and the dentist providing the service (see section titled "Selecting Your Dentist"). Dentists are required to collect your copayment for covered services.

It is to your advantage to select PPO Dentists because they have agreed to accept the PPO Allowed Amount as payment, which typically results in lower copayments charged to you. Please read the sections titled "Selecting Your Dentist" and "How Claims Are Paid" for more information.

Deductible

Most dental plans have a specific dollar deductible. The Benefit Summary Charts show the individual and family deductibles that apply, depending on the participation status of the dentist providing the services. Deductibles apply to all benefits unless otherwise noted. Each enrolled family member must pay the individual deductible amount each contract year to satisfy the plan deductible. You pay this directly to your dentist for completed services. The total deductible amount paid will not exceed the family deductible for all family members.

Maximum Benefit

Most dental programs have a maximum benefit. This is the maximum dollar amount a dental plan will pay toward the cost of dental care. The Member is personally responsible for paying costs above the maximum benefit. The Benefit Summary Charts show the maximum benefit amount that applies, depending on the participation status of the dentist providing the services. This is the maximum benefit amount that Delta Dental will pay for covered services per Member in a contract year.

Note on Additional Benefits During Pregnancy

When an Member is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Member during the pregnancy. The additional services while the Member is covered under the Contract include: one (1) additional oral exam and either one (1) additional routine cleaning or one (1) additional periodontal scaling and root planing per quadrant. Written confirmation of the pregnancy must be provided by the Member or her dentist when the claim is submitted.

Limitations and Exclusions

Dental plans are designed to help with part of your dental expenses and may not always cover every dental need. The typical program includes limitations and exclusions, meaning the program does not cover every aspect of dental care. This can relate to the type of procedures or the number of visits. These limitations and exclusions are carefully detailed in this booklet and you should make yourself familiar with them. Please read the **Limitations and Exclusions** section to help you understand the limitations and exclusions of this dental plan.

HOW CLAIMS ARE PAID

Payment by Delta Dental for any single procedure that is a covered service will be made upon completion of the procedure. Payment for care is applied to the contract year deductible and maximum benefit based on the date of service. After you have satisfied your deductible requirement, Delta Dental will provide payment for covered services at the percentage indicated in the Benefit Summary Chart, up to a maximum for each Member in a contract year.

Payment for Services — Delta Dental PPO Dentist

Payment for covered services performed for you by a PPO Dentist is calculated based on the PPO Allowed Amount. PPO Dentists have agreed to accept a PPO Allowed Amount as the full charge for covered services.

Delta Dental calculates its share of the PPO Allowed Amount ("Delta Dental Payment") using the applicable percentage from the Benefit Summary Chart and sends it directly to the PPO Dentist who has submitted the claim. Delta Dental advises you of any charges not payable by Delta Dental for which you are responsible ("Member Payment"). These charges are generally your share of the allowed amount ("Co-payment"), the deductible, charges where the maximum benefit has been exceeded, and/or charges for non-covered services.

Example (assuming this is a procedure that is covered at a 50%/50% copayment level, the maximum benefit has not been exceeded and the deductible has been met):

Submitted Amount (Dentist Fee)	=	$100
PPO Maximum Plan Allowance	=	$70
PPO Allowed Amount	=	$70
Co-payment (50% of PPO Allowed Amount)	=	$35
Delta Dental Payment	=	$35
Member Payment	=	$35

Payment for Services — Delta Dental Premier Dentist

A Delta Dental Premier Dentist is a participating dentist, but is not a Delta Dental PPO Dentist. Premier Dentists have not agreed to accept a PPO Allowed Amount as full payment for services, but instead have agreed to accept a Premier Allowed Amount. Payment for covered services performed for you by a Premier Dentist is calculated based on the Premier Allowed Amount, which is the lesser of the dentist's submitted fee or the Premier Maximum Plan Allowance.

The portion of the Premier Allowed Amount payable by Delta Dental ("Delta Dental Payment") is limited to the applicable percentage shown in the Benefit Summary Chart. Delta Dental's Payment is sent directly to the Premier Dentist who submitted the claim. Delta Dental advises you of any charges not payable by Delta Dental for which you are responsible ("Member Payment"). These charges are generally your share of the Premier Allowed Amount, as well as any deductibles, charges where the maximum benefit has been exceeded, and/or charges for non-covered services.

Example (assuming this is a procedure that is covered at a 50%/50% copayment level, the maximum benefit has not been exceeded and the deductible has been met):

Submitted Amount (Dentist Fee)	=	$100
Premier Maximum Plan Allowance	=	$80
Premier Allowed Amount	=	$80
Co-payment (50% of Premier Allowed Amount)	=	$40
Delta Dental Payment	=	$40
Member Payment	=	$40

Payment for Services — Non-Participating Dentist

Non-participating Dentists have not agreed to accept the PPO Allowed Amount as full payment for services. Payment for services performed for you by a Non-participating Dentist is also calculated by Delta Dental based on the Non-participating Dentist Allowed Amount, which is the lesser of the dentist's submitted fee or the Non-participating Dentist Maximum Plan Allowance. The portion of the Non-participating Dentist Allowed Amount payable by Delta Dental ("Delta Dental Payment") is limited to the applicable percentage shown in the Benefit Summary Chart.

However, when dental services are received from a Non-participating Dentist, Delta Dental's payment is sent directly to the primary Member. You are responsible for payment of the Non-participating Dentist's total fee. Non-participating Dentists will bill you for their normal charges, which may be higher than the Non-participating Dentist Allowed Amount for the service. You may be required to pay the dentist yourself and then submit a claim to Delta Dental for reimbursement. Since the Delta Dental payment for services you receive may be less than the Non-participating Dentist's actual charges, your out-of-pocket cost may be significantly higher.

Example (assuming this is a procedure that is covered at a 50%/50% copayment level, the maximum benefit has not been exceeded and the deductible has been met):

Submitted Amount (Dentist Fee)	=	$100
Non-participating Dentist Maximum Plan Allowance	=	$80
Non-participating Dentist Allowed Amount	=	$80
Co-payment (50% of Non-participating Dentist Allowed Amount)	=	$40
Delta Dental Payment	=	$40
Member Payment	=	$60

Note: The Member balance of $60 is the sum of the Member co-payment (50% of the Non-participating Allowed Amount of $80, which is $40) and the difference between the Non-participating Dentist Allowed Amount and the Submitted Amount, which is $20.

Orthodontic Payments

Unless otherwise specified in the contract, Delta Dental will pay half of its orthodontic payment up front, at the time of banding. (Delta Dental's orthodontic payment is calculated in the same manner as the "Delta Dental Payment" in the above examples.) The remaining half will be paid one year later. If the treatment time is 12 months or less, Delta Dental's orthodontic payment will be paid as a lump sum at the beginning of the orthodontic treatment. If treatment began prior to the Member becoming eligible with Delta Dental, any payments made by a previous dental carrier will be applied to the Member's lifetime orthodontic maximum.

How to Submit a Claim

Delta Dental does not require any special claim forms. Most dental offices have standard claim forms available. Participating Dentists will fill out and submit your claims paperwork for you. Some Non-participating Dentists may also provide this service upon your request. If you receive services from a Non-participating Dentist who does not provide this service, you can submit your own claim directly to Delta Dental. For your convenience, you can print a claim form from our web site: www.deltadentalins.com.

Your dental office should be able to assist you in filling out the claim form. Fill out the claim form completely and mail it to:

Delta Dental
P.O. Box 2105
Mechanicsburg, PA 17055-6999

Payment Guidelines

Delta Dental does not pay Participating Dentists any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If you or your dentist files a claim for services more than twelve (12) months after the date you received the services, payment may be denied. If the services were received from a Non-participating Dentist, you are still responsible for the full cost. If the payment is denied because your Participating Dentist failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your Participating Dentist that you were a Member of the plan at the time you received the service, you may be responsible for the cost of that service.

We explain to all Participating Dentists how we determine or deny payment for services. We describe in detail the dental procedures covered as benefits, the conditions under which coverage is provided and the program's limitations and exclusions. If any claims are not covered, or if limitations or exclusions apply to services you have received, you may be responsible for the full payment.

If you have any questions about any dental charges, processing policies and/or how your claim is paid, contact Delta Dental.

Optional Treatment and Non-Covered Services

You must pay for any non-covered or optional dental benefits that you choose to have done. Refer to the **Limitations and Exclusions** section for information about excluded services and limitations.

Often there are several approaches or different methods that a dentist may use to treat dental needs. This program is designed to cover dental treatment using standards of care consistent with the delivery of quality, affordable dental treatment to the Member. If you request a treatment that is more costly than standard practice, you must pay for the charges in excess of the covered dental benefit.

Example: If a metal filling would fix the tooth and you choose to have the tooth crowned, you are responsible for paying the difference between the cost of the crown and the cost of the filling. You must pay this money directly to your dentist.

Pre-Treatment Estimates

If you and your dentist are unsure of your benefits for a specific course of treatment, or if treatment costs are expected to exceed $300, Delta Dental recommends that you ask for a pre-treatment estimate. You should ask your dentist to submit the claim form in advance of performing the proposed services. Pre-treatment estimate requests are not required but may be submitted for more complicated and expensive procedures such as crowns, wisdom tooth extractions, bridges, dentures, or periodontal surgery. You'll receive an estimate of your share of the cost and how much Delta Dental will pay before treatment begins. Delta Dental will act promptly in returning a pre-treatment estimate to you and the attending dentist with non-binding verification of your current availability of benefits and applicable maximums. The pre-treatment estimate is non-binding as the availability of benefits may change subsequent to the date of the estimate due to a change in eligibility status, exhaustion of applicable maximum benefit or application of frequency of procedure limitations.

Other Health Insurance

Be sure to advise your dentist of all programs under which you have dental coverage and have him or her complete the dual coverage portion of the claim form, so that you will receive all benefits to which you are entitled. When you have coverage under more than one benefit program, the primary and secondary carriers coordinate the two programs, so that the primary carrier pays its portion first and then the secondary carrier pays its portion, not to exceed the dentist's fees for the covered services.

The following rules will be followed to establish the order of determining the liability of this or any other programs:

1. The program covering the Member as an employee will determine its benefits before the program covering the Member as a dependent.

2. The program covering the Member as a dependent of an employee whose birthday falls earlier in the calendar year will determine it benefits before the program covering the Member as a dependent of an employee whose birthday falls later in the calendar year. If both employees have the same birthday, the program covering the employee for the longest period will be primary over the program covering the employee for the shorter period.

3. The program covering the Member having custody of the dependent will determine its benefits first; then the program of the spouse of the parent with custody of the dependent; and finally, the program of the parent not having custody of the dependent. However, if the specific terms of a court order state that one of the parents is responsible for the health care expenses of the dependent, the benefits of that program are considered first. The prior sentence will not apply with respect to any period during which any benefits are actually paid or provided before a program has actual knowledge of the court order.

4. The program covering the Member as an employee or as a dependent of an employee will determine its benefits before one that covers the Member as a laid-off or retired employee or as the dependent of such person. If the other plan does not have a rule concerning laid-off or retired employees, and as a result each plan determines its benefits after the other, then this paragraph will not apply.

5. If the other program does not have a rule establishing the same order of determining liability for benefits or is one which is "excess" or always "secondary," Delta Dental will determine its benefits first. If such determination indicates that Delta Dental should not have been the first program to determine its benefits, Delta Dental will be considered as not the first to determine its benefits.

6. In situations not described in items 1 through 5, the program under which the Member has been enrolled for the longest period of time will determine its benefits first.

When Delta Dental is the first to determine its benefits, benefits will be paid without regard to coverage under any other program. When Delta Dental is not the first to determine its benefits, and there are remaining expenses of the type allowable under this program, Delta Dental will pay only the amount by which its benefits under this plan exceed the amount of benefits payable under the other program or the amount of such remaining expenses, whichever is less.

ELIGIBILITY AND ENROLLMENT

Eligibility Requirement

You will become eligible to receive benefits on the date stated in the contract after completing any eligibility periods required by the group. Under this dental plan, the eligibility requirement for new hires is the 1st of the month following date of hire. You may enroll for individual and family coverage.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents. Dependents shall be defined as the lawful spouse, including a partner to a civil union, of the Primary Member and children or legal dependents that have attained the age of twenty-six (26) regardless of marital or college enrollment status. Children or legal dependents of a Primary Member's dependent are not eligible. Coverage for dependent children terminates at the end of the month of employment by the Primary Member or the month the dependent child attains the age of twenty-six (26). Newborn children of any Primary Member or newborn child of the spouse of any Primary Member are eligible for coverage for thirty-one (31) days after birth.

Changes in Eligibility Status

Changes in eligibility status (i.e. marriage, divorce, birth, graduation, etc.) must be reported to the Plan Administrator within 31 days following the event causing the change. If you do not change coverage when first eligible, you may change later during a subsequent open enrollment period. Changes become effective on the exact day of notification of the change.

Loss of Eligibility

Your coverage ends on the last day of the month in which termination of employment occurs or immediately when this program ends. Coverage for all dependents also ceases at that time, or when dependent status is lost. Your dependent children and/or grandchildren will be disqualified for benefits when they reach the disqualifying age.

COMPLAINTS, GRIEVANCES AND APPEALS

Our commitment to you is to ensure quality throughout the entire treatment process: from the courtesy extended to you by our customer service representatives to the dental services provided by our Participating Dentists. If you have questions about any services received, we recommend that you first discuss the matter with your dentist. However, if you continue to have concerns, please call Delta Dental's Customer Service Center.

Delta Dental attempts to process all claims within 30 days. If a claim will be delayed more than 30 days, Delta Dental will notify the Member in writing within 30 days stating the reason for delay.

Questions or complaints regarding eligibility, the denial of dental services or claims, the policies, procedures, or operations of Delta Dental, or the quality of dental services performed by the dentist may be directed in writing to Delta Dental or by calling Delta Dental at (717) 766-8500 or toll-free at (800) 932-0783. You can also e-mail questions by accessing the "Contact Us" section of Delta Dental's web site at www.deltadentalins.com.

A grievance is a written expression of dissatisfaction with the provision of services or claims practices of Delta Dental. When you write, please include the name of the Member, the primary Member's name and Member ID, and your telephone number on all correspondence. You should also include a copy of the claim form, Benefits Statement, Invoice or other relevant information.

Appeals

Any dissatisfaction with adjustments made or denials of payment should be brought to Delta Dental's attention, and if unresolved to your satisfaction, to the Plan Administrator. The Plan Administrator will advise you of your rights of appeal or other recourse.

Appeals on claims denied must be submitted in writing. The following section explains the claim review and appeal process and time limits applicable to such process. This information can also be found in your Benefits Statement.

If a post-service claim is denied in whole or in part, Delta Dental will notify you and your attending dentist of the denial in writing within 30 days after the claim is filed, unless special circumstances require an extension of time, not exceeding 14 days, for processing. If there is an extension, you and your attending dentist will be notified of the extension and the reason for the extension within the original 30-day period. If an extension is necessary because either you or your attending dentist did not submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. You or your attending dentist will be afforded at least 45 days from receipt of the notice within which to provide the specific information. The extension period (15 days) – within which a decision must be made by Delta Dental – will begin to run from the date on which the your response is received by the plan (without regard to whether all of the requested information is provided) or, if earlier, the due date established by the plan for furnishing the requested information (at least 45 days).

The notice of denial shall explain the specific reason or reasons why the claim was denied in whole or in part, including a specific reference to the pertinent contract provisions on which the denial is based, a description of any additional material or information necessary for you to perfect the claim and an explanation as to why such information is necessary. The notice of denial shall also contain an explanation of Delta Dental's claim review and appeal process and the time limits applicable to such process, including a statement of the Member's right to bring a civil action under ERISA upon completion of Delta Dental's second level of review. The notice shall refer to any internal rule, guideline, and protocol that was relied upon (and that a copy will be provided free of charge upon request). The notice shall state that if the claim denial is based on lack of dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, an explanation is available free of charge upon request by you or your attending dentist.

If you or your attending dentist wants the denial of benefits reviewed, you or your attending dentist must write to Delta Dental within 180 days of the date on the denial letter. In the letter, you or your attending dentist should state why the claim should not have been denied. Also any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice should accompany the request for review. You or your attending dentist are entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination.

The review shall be conducted on behalf of Delta Dental by a person who is neither the individual who made the claim denial that is the subject of the review, nor the subordinate of such individual. If the review is of a claim denial based in whole or in part on a lack of dental necessity, experimental treatment, or a clinical judgment in applying the terms of the contract, Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta Dental dental consultant whose advice was obtained in connection with the denial of the claim whether or not the advice was relied upon in making the benefit determination is also available to you or your attending dentist on request. In making the review, Delta Dental will not afford deference to the initial adverse benefit determination.

If after review, Delta Dental continues to deny the claim, Delta Dental will notify you and your attending dentist in writing of the decision on the request for review within 30 days of the date the request is received. Delta Dental will send to you or your attending dentist a notice, which contains the specific reason or reasons for the adverse determination and reference to the specific contract provisions on which the benefit determination is based. The notice shall state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. The notice shall refer to any internal rule, guideline, and protocol that was relied upon (and that a copy will be provided free of charge upon request). The notice shall state that if the claim denial is based on lack of dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, an explanation is available free of charge upon request by either you or your attending dentist. The notice shall also state that you have a right to bring an action under ERISA upon completion of Delta Dental's second level of review, and shall state: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If in the opinion of you or your attending dentist, the matter warrants further consideration, you or your attending dentist should advise Delta Dental in writing as soon as possible. The matter shall then be immediately referred to Delta Dental's Dental Affairs Committee. This stage can include a clinical examination, if not done previously, and a hearing before Delta Dental's Dental Affairs Committee if requested by you or your attending dentist. The Dental Affairs Committee will render a decision within 30 days of the request for further consideration. The decision of the Dental Affairs Committee shall be final insofar as Delta Dental is concerned. Recourse thereafter would be to the state regulatory agency, a designated state administrative review board, or to the courts with an ERISA or other civil action.

Send your grievance, appeal, or claims review request to Delta Dental at the address shown below:

Delta Dental
One Delta Drive
Mechanicsburg, PA 17055

GENERAL PROGRAM INFORMATION

Proof of Claim

Before approving a claim, Delta Dental will be entitled to receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which a dentist's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, an Member as may be required to administer the claim, or that an Member be examined by a dental consultant retained by Delta Dental, in or near the community or residence. Delta Dental will in every case hold such information and records confidential.

Physical Access

Delta Dental has made efforts to ensure that our offices and the offices and facilities of Participating Dentists are accessible to the disabled. If you are not able to locate an accessible dentist, please call our Customer Service Center and a representative will help you find an alternate dentist.

Access for the Hearing Impaired

The hearing impaired may contact the Customer Service Center through our toll-free TTY/TDD number at (888) 373-3582.

Privacy

Delta Dental values its relationship with you. Protecting your personal information is of great importance to us. Delta Dental will obtain from the Member only nonpublic information that relates to Delta Dental's administration of the dental benefits we provide. Information may include, but not be limited to name, address, social security number, Member ID, and date of birth. We do not disclose any nonpublic personal information about you to any affiliated or nonaffiliated third parties except as is necessary in order to provide our service to you or as we are required or permitted by law. Delta Dental maintains physical, electronic, and procedural security measures to safeguard your nonpublic personal information in our possession.

Web Site Security

Delta Dental employs security measures to control access to the eligibility and dental benefit information under our control. Delta Dental uses industry standards, such as firewalls and Secure Socket Layers, to safeguard the confidentiality of personal Member information.

There are areas of our web site that require a specific user ID and password for web site access. In order to receive a user ID and password, Delta Dental requires Members to contractually agree to not provide information they may access to other individuals. The user identification and password required for site access is internally validated to ensure this information cannot be viewed without proper authority and security authentication.

Reduction for Automobile Insurance Benefits *(For Pennsylvania Members Only)*

Fees for services or supplies for injuries or conditions payable under this plan will be reduced by the amount of any first party benefits under automobile insurance and by any catastrophic loss benefits paid by the Catastrophic Loss Trust Fund. Fees not paid as first party benefits will be payable proportionately as the obligation of Delta Dental and Member in the percentages shown in the Benefit Summary Chart.

Any deductible will be considered satisfied to the extent of first party benefits under automobile insurance and by any catastrophic loss benefits paid by the Catastrophic Loss Trust Fund.

MEMBER RIGHTS AND RESPONSIBILITIES

We believe that you, as a Delta Dental Member, have the right to expect quality, affordable care that protects not only your dental health, but also your privacy and ability to make informed choices. We also believe that you have certain responsibilities to help protect these rights.

The Right to Choose

The Delta Dental system maintains some of the largest dentist networks in the industry — each with a full range of specialists — to give you the widest possible choice of dentists. Dentists are never penalized for referring you to a specialist. You can visit any dentist at any time, without prior notification or authorization from Delta Dental.

The Right to Quality Assurance

While we support the right of Members to choose their dentist, we recognize our responsibility to provide some assurances of quality care.

Therefore, each dentist who has contracted with Delta Dental agrees to provide care that meets the standards of the dental profession. Dentist contracts allow Delta Dental to audit dental offices in person — at random and for cause — to help ensure that these standards are met. If you should ever receive substandard care from a Delta Dental dentist, Delta Dental will fully investigate the matter and can arrange for you to be reimbursed and/or retreated as needed.

The Right to Affordability

Delta Dental contracts with dentists to provide fair and reasonable compensation. Those contracts also prohibit dentists from billing you for excess charges, "add-on" procedures that should already be included, or for any amount that is Delta Dental's responsibility.

Delta Dental benefit plans are designed to promote preventive care, avoiding dental disease before more costly treatment becomes necessary.

The Right to Full Disclosure

You have the right to clear and complete information about your dental benefits, including treatment that is subject to limitations or not covered. You are entitled to know what your share of costs will be before you receive treatment ("pre-treatment estimate"), and how your dentist is compensated by Delta Dental. Delta Dental provides materials to explain these features to you.

Delta Dental dentists are not subject to policies sometimes called "gag clauses." You are entitled to hear about all treatment options your dentist may recommend, whether covered or not, and to obtain a second opinion if you choose.

The Right to Fair Review and Appeal

Delta Dental supports your right, as well as your dentist's, to a fair and prompt review of any of Delta Dental's coverage decisions. We maintain effective complaint resolution systems in the event of disagreement over coverage or concern about the quality of care.

The Responsibility to Protect These Rights

Protection of the rights described above is possible only with your cooperation. In order to ensure the continued enjoyment of these rights, you share:

- The responsibility to participate in your own dental health — practicing personal dental hygiene and receiving regular professional care. You should avoid substances and behaviors that could jeopardize your oral health, and should cooperate with your dentist on his or her recommended treatment plans.

- The responsibility to become familiar with your coverage. This includes meeting any financial obligation incurred as a result of treatment (including the appropriate copayments or deductibles required by the program). It means cooperation with Delta Dental policies designed to protect against health care fraud schemes by fellow Members or dentists. It also means taking advantage of the information available on dental health and your dental program so that you can become a more informed consumer.

LIMITATIONS AND EXCLUSIONS

Excluded Benefits

The plan covers a wide variety of dental care expenses, but there are some services for which we do not provide benefits. It is important for you to know what these services are before you visit your dentist.

The plan does not provide benefits for:

1. Treatment or materials that are benefits to a Member under Medicare or Medicaid unless this exclusion is prohibited by law.

2. Treatment or materials to correct congenital or developmental malformations (including treatment of enamel hypoplasia) except for newborn children eligible at birth, so long as such eligible children continue to be enrolled. When services are not excluded under this provision congenital defects or anomalies specifically includes individuals born with cleft lip or cleft palate, and other limitations and exclusions of this section shall specifically apply.

3. Treatment that increases the vertical dimension of an occlusion, replaces tooth structure lost by attrition or erosion, or otherwise unless it is part of a treatment dentally necessary due to accident or injury.

4. Treatment or materials primarily for cosmetic purposes including but not limited to treatment of fluorosis (a type of discoloration of the teeth) and porcelain or other veneers not for restorative purposes, except as part of a treatment dentally necessary due to accident or injury. If services are not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent or near the affected teeth are excluded.

5. Treatment or materials for which the Member would have no legal obligation to pay.

6. Services provided or materials furnished prior to the effective eligibility date of a Member under this plan, unless the treatment was a year in duration and completed after the Member became eligible if no other limitations shall apply.

7. Periodontal splinting, equilibration, gnathological recordings and associated treatment and extra-oral grafts.

8. Preventive plaque control programs, including oral hygiene instruction programs.

9. Myofunctional therapy, unless covered by the exception in Item 2, above.

10. Temporomandibular joint dysfunction, unless covered by the exception in Item 2, above.

11. Prescription drugs including topically applied medication for treatment of periodontal disease, pre-medication, analgesias, separate charges for local anesthetics, general anesthesia except as a covered benefit in conjunction with a covered oral surgery procedure.

12. Implants and related services, unless covered by the exception Item 2, above.

13. Experimental procedures that have not been accepted by the American Dental Association.

14. Services provided or material furnished after the termination date of coverage for which premium has been paid, as applicable to individual Members, except this shall not apply to services commenced while the plan was in effect or the Member was eligible.

15. Charges for hospitalization or any other surgical treatment facility, including hospital visits.

16. Dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks, or relaxation techniques such as music.

17. Replacement of existing restorations for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.

Limitations

Benefits to Members are limited as follows:

Limitation on Optional Treatment Plan. In all cases in which there are optional plans of treatment carrying different treatment costs, payment will be made only for the applicable percentage of the least costly course of treatment, so long as such treatment will restore the oral condition in a professionally accepted manner, with the balance of the treatment cost remaining the responsibility of the Member. Such optional treatment includes, but is not limited to, specialized techniques involving gold, precision partial attachments, overlays, implants, bridge attachments, precision dentures, personalization or characterization such as jewels or lettering, shoulders on crowns or other means of unbundling procedures into individual components not customarily performed alone in generally accepted dental practice.

Limitation on Major Restorative Benefits. If a tooth can be restored with amalgam, synthetic porcelain or plastic, but the Member and the dentist select another type of restoration, the obligation of Delta Dental shall be only to pay the applicable percentage of the fee appropriate to the least costly restorative procedure. The balance of the treatment shall be considered a dental treatment excluded from coverage under this plan.

- Replacement of crowns, jackets, inlays and onlays shall be provided no more often than once in any five-year period and then only in the event that the existing crown, jacket, inlay or onlay is not satisfactory and cannot be made satisfactory. The five-year period shall be measured from the date on which the restoration was last supplied, whether paid for under the provisions of this plan, under any prior dental care contract, or by the Member.

Limitation on Prosthodontic Benefits. Replacement of an existing denture will be made only if it is unsatisfactory and cannot be made satisfactory. Services, including denture repair and relining, which are necessary to make such appliances fit will be provided as outlined in the section "Covered Benefits." Prosthodontic appliances and abutment crowns will be replaced only after five years has elapsed following any prior provision of such appliances and abutment crowns under any plan procedure.

Limitation on Orthodontic Benefits. Orthodontic benefits are limited to devices and procedures for the correction of malposed teeth of employees, spouses and dependents up to age 26, through the completion of the procedures; or to the date coverage terminates, which ever occurs first. The obligation of Delta Dental to make monthly or other periodic payments for orthodontic treatment will cease upon termination of treatment for any reason, prior to completion of the procedure. Delta Dental will not make any payment for repair or replacement of orthodontic appliances.

Limitation on Oral Surgery Benefits. Benefits for specific oral surgery procedures, including but not limited to reduction of fractures, removal of tumors, and removal of impacted teeth payable under a medical insurance contract or a medical or hospital service contract by which the Member is covered shall be determined first under this plan. Delta Dental's obligation for these oral surgery services shall be limited to the difference between benefits paid under such other contracts up to the applicable allowed amount for the procedure less the applicable deductible and Member copayment. When there is no medical or hospital coverage, Delta Dental's obligation for oral surgery services shall be limited to the applicable allowed amount for those services provided under the contract less the applicable deductible and Member copayment.

Limitation on Periodontal Surgery. Benefits for periodontal surgery in the same quadrant are limited to once in any two-year period. The two-year period shall be measured from the date on which the last periodontal surgery was performed in that quadrant, whether paid for under the provisions of this plan, under any prior dental contract, or by the Member.

Limitation on Sealants. Treatment with sealants as a covered Service is limited to applications to eight posterior teeth. Applications to deciduous teeth or teeth with caries are not covered Services. Sealants will be replaced only after three (3) years have elapsed following any prior provision of such materials.

Limitation on Occlusal Restorations. Single-surface occlusal restorations of a tooth to which a sealant has been applied within twelve months, and two or three surface restorations within six months, which include occlusal surfaces on which sealants have been placed are not covered Services. If a single-surface occlusal restoration is performed on a tooth from twelve to thirty-six months after a sealant has been applied to that tooth, the obligation of Delta Dental shall be only to pay the fee appropriate to the restoration in excess of the fee paid for the application of the sealant.

DEFINITION OF TERMS

The following are definitions of words that have special or technical meanings under the plan.

Attending Dentist Statement: The written report of a series of procedures recommended for the treatment of a specific dental disease, defect or injury, prepared for an Member by a dentist as a result of an examination made by such dentist.

Benefits Statement: The statement you receive after a claim is processed, detailing how your claim payment was calculated including the procedures and fees submitted and the amount for which you are responsible.

Claim Form: A written or electronically submitted document to request payment for completed dental treatment or to request a pre-treatment estimate for proposed dental treatment. The claim form is also sometimes called an Attending Dentist's Statement.

Company: The employer, union or other organization or group contracting to obtain benefits.

Contract: The written agreement between Delta Dental and State of Delaware to provide dental benefits. The contract, together with this Evidence of Coverage, forms the terms and conditions of benefits available to you under the dental plan.

Contract Year: The 12-month period beginning on the effective date and each yearly period thereafter.

Copayment: Your share of the cost of a covered service, usually expressed as a percentage of the applicable allowed amount.

Deductible: The dollar amount Members must pay toward completed treatment before Delta Dental's payment is applied to those services in a given period.

Delta Dental PPO with Point of Service (POS) Option: A dental care program under which all fees paid by Delta Dental for covered services provided by a PPO Dentist shall be based on the PPO Allowed Amount, subject to any applicable copayments, deductibles and maximums. All fees paid by Delta Dental for covered services provided by a Premier Dentist who is not a PPO Dentist shall be based on the Premier Allowed Amount and all fees paid by Delta Dental for covered services provided by a Non-participating Dentist shall be based on the Non-participating Dentist Allowed Amount.

Delta Dental PPO ("PPO") Dentist: A Participating Dentist who is a member of the Delta Dental PPO Dentist network.

Delta Dental Premier ("Premier") Dentist: A Participating Dentist who is a member of the Delta Dental Premier Dentist network.

Delta Dental PPO ("PPO") Maximum Plan Allowance: The maximum amount, determined by Delta Dental, usually less than its Maximum Plan Allowance for Delta Dental Premier programs, from claim charges submitted on a regional basis for a given service by dentists of similar training within the same geographical area blended by Delta Dental with dentist fee information from a number of other sources, including dentist fee filings, using various factors, subject to regulatory limitations and adjustment for extreme difficulty or unusual circumstances.

Delta Dental Premier ("Premier") Maximum Plan Allowance: The maximum amount payable for services of Participating Dentists, calculated by Delta Dental, for use in payment by it and by its Members from claim charges submitted, on a regional basis, for a given service by dentists of similar training within the same geographical area blended by Delta Dental with dentist fee information from a number of other sources, including dentist fee filings, using various factors, subject to regulatory limitations and adjustment for extreme difficulty or unusual circumstances.

Delta Dental Payment: The portion of the PPO Allowed Amount, the Premier Allowed Amount or the Non-participating Dentist Allowed Amount payable by Delta Dental.

Dependent: Eligible family members as defined in the **Eligibility and Enrollment** section of this Evidence of Coverage.

Effective Date: The date the dental program begins. This date is given on the front cover of this Evidence of Coverage.

Employee: An employee of the company who meets the eligibility requirements, accepted by Delta Dental, for enrollment under the contract, and who is so specified for enrollment.

Member: Collectively, the primary Member and all enrolled dependents.

Member Payment: The amount the Member pays after calculation of the Delta Dental payment.

Exclusions: Services that are not covered under this dental plan.

Family: The primary Member and all enrolled dependents of the primary Member.

Limitations: The number of services allowed, frequency of services allowed, and the most affordable dentally appropriate service.

Maximum Benefit: The total maximum dollar amount Delta Dental will pay toward the cost of covered dental care incurred by an individual Member in a given period.

Network: A collective expression for all participating dentists who have contracted with Delta Dental to offer services to Members and who have agreed to abide by certain administrative guidelines.

Non-Participating Dentist: A dentist who has not contracted with Delta Dental and who is not contractually bound to abide by Delta Dental's administrative guidelines.

Non-Participating Dentist Allowed Amount: For covered services, the Non-participating Dentist Allowed Amount under this plan is the lesser of the dentist's submitted fee or the Non-participating Dentist Maximum Plan Allowance. For non-covered services, the Non-participating Dentist Allowed Amount is zero.

Non-Participating Dentist Maximum Plan Allowance: The maximum amount payable by Delta Dental for a covered dental service if the Member is enrolled in a Delta Dental PPO program. Delta Dental defines the Non-participating Dentist Maximum Plan Allowance for each procedure up to the 80th percentile of FairHealth as published in the FH™ Benchmarks. The Member's financial obligation beyond the Non-participating Dentist Maximum Plan Allowance is determined by any maximums, deductible and co-payment amounts.

Out-of-Pocket Costs: The portion of dental fees that you pay. Out-of-pocket costs include your deductible, copayment, any amount exceeding the maximum benefit amount, and services not covered by the dental plan.

Participating Dentist: A dentist who contracts with Delta Dental and agrees to abide by certain administrative guidelines.

PPO Allowed Amount: For covered services, the PPO Allowed Amount is either the Delta Dental PPO Maximum Plan Allowance for PPO Dentists, or the charged fee, whichever is less. For non-covered services, the PPO Allowed Amount is zero.

Premier Allowed Amount: For covered services, the Premier Allowed Amount is either the Delta Dental Premier Maximum Plan Allowance or the charged fee, whichever is less. For non-covered services, the Premier Allowed Amount is zero.

Pre-Treatment Estimate: A pre-treatment estimate gives a non-binding estimate of how much of a proposed treatment plan will be covered under a Member's dental program and what the Member's out-of-pocket cost will be.

Primary Member: An employee who is enrolled in this dental plan.

Services: Treatment performed by a dentist or under his/her supervision and direction and when necessary, customary and reasonable, as determined by Delta Dental, using standards of generally accepted dental practice.

Single Procedure: A dental procedure to which a separate procedure number is assigned by Delta Dental.

Submitted Amount: The amount the dental office actually submits on the claim form. This is the fee normally charged by the dentist for services provided to all Members, regardless of insurance coverage.

Treatment: A caring for or dealing with an oral condition.