

Delta Dental of Virginia  
PO Box 103  
Stevens Point, WI 54481-0103

## Delta Dental of Virginia

### WELCOME

Delta Dental of Virginia (DDVA) is pleased to bring these important Benefits to you and any Dependents you have enrolled for coverage. **Please read this entire Policy carefully so that you will be aware of its Benefits, limitations and other terms and conditions.**

The terms “you” and “your” refer to the person(s) enrolled under this Policy. The terms “we”, “us” and “our” refer to DDVA.

This Policy is issued by DDVA and delivered in Virginia. All terms, conditions and other provisions of this Policy are governed by Virginia law applicable to limited-scope dental policies. All Benefits are paid according to the terms, conditions and provisions of this Policy. Please see the “Schedule of Dental Benefits, Limitations and Fixed Patient Copayments” section for the list of covered Benefits for which you have Fixed Patient Copayments.

DDVA processes claims based upon a Maximum Plan Allowance, which may be less than the provider’s billed charge. Please see the “Your Choice of Dentist” section in this Policy for more details.

Please read this Policy carefully and completely and refer to it should you have questions on your dental coverage. This Policy is our complete agreement with you and will govern your dental coverage. Each term in this Policy that is capitalized has a special meaning and is defined in the “Definitions” section.

### Important Notice Concerning Statements in the Application for Your Policy

A summary page of your completed Application is a part of this Policy and is attached. If the Application is not complete or has an error, please let us know. If your answers are incorrect or untrue, we may have the right to deny Benefits or rescind your Policy. If, for any reason, any part of the Application is incorrect, please contact us.

### Your Right to Return this Policy

Please read this Policy immediately. If you are not satisfied with it for any reason, you have ten (10) days to review it and notify us that you are not satisfied with the Policy. Once we receive your notification within ten (10) days from your receipt of the Policy stating that you are not satisfied, we will void the Policy and the refund Premium paid, less any claim payments issued.

### Effective Date and Policy Term

The Effective Date of this Policy is the first day of the month following the month in which DDVA accepts your Application for coverage. The Effective Date will be shown on your Application for this Policy. This Policy will remain in effect for 12 months from the Effective Date and cannot be cancelled by you except for limited reasons that are listed in this Policy under “Termination of This Policy.” If you terminate this Policy according to the Policy terms, you must wait 24 months before we will issue you another Policy.

## Renewability

This Policy is renewable at the option of DDVA. Premium rates may change at renewal but we will notify you of the new Premium at least 30 days before the beginning of the renewal Policy Period. However, when this Policy's rate is increased for a renewal Policy Period, DDVA will send you a written notice at least 75 days before the renewal Policy Period. If any Benefits under your Policy are decreased, DDVA will send you a written notice of the new Benefits at least 60 days before the renewal Policy Period.

## Eligibility

**Only Virginia residents 18 and older or emancipated minors who are not covered under another policy or plan that covers Dental Procedures may purchase this Policy for themselves and their Dependents. This Policy does not contain an age limit for coverage of Dependents.**

You may make address or credit card changes at any time by going online to [www.DeltaDentalCoversMe.com](http://www.DeltaDentalCoversMe.com). You may also view and print information about your Benefits and claims at this website or use this website to add or delete persons covered by this Policy in accordance with the Policy terms. The online program will notify you of your new premium and the Effective Date of coverage or termination of coverage.

As a Managed Care Health Insurance Plan operating in the Commonwealth of Virginia, DDVA 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).

This Policy constitutes the entire agreement and understanding between you and DDVA, including Policy schedules, amendments or riders made a part of the Dental Policy

DELTA DENTAL OF VIRGINIA

By: *SA Lucchi*

Title: President and CEO

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PD.IFC#TOC [09.2010]



## DEFINITIONS

“Appeal” means a request to change an adverse benefit determination where the decision DDVA makes results in denial, reduction or termination of a benefit or amount paid. It also means a decision not to provide a benefit or service.

“Application” means your request for coverage under this Policy. If we accept your Application, it will become a part of the Policy.

“Benefit” or “Benefits” means those Dental Procedures that are covered by DDVA under the terms of your Policy, as specified in the “Schedule of Dental Benefits, Limitations and Fixed Patient Copayments” section of this Policy.

“Covered Dependent” means a Dependent who (a) is listed on the Application that is a part of this Policy; (b) has been accepted by DDVA as a Covered Dependent; and (c) for whom the appropriate Premium has been paid.

“Delta Dental” means Delta Dental Plans Association, which is a nationwide non-profit organization of health care service plans, which offers a range of group dental Benefit Plans.

“Delta Dental of Virginia” or “DDVA” is a nonprofit corporation incorporated in Virginia. Delta Dental of Virginia is a member of the Delta Dental Plans Association.

“Delta Dental PPO Dentist” means (1) any Dentist who has entered into a Delta Dental PPO Dentist agreement to provide or arrange for the provision of Dental Procedures to Policyholders and Covered Dependents and who abides by Delta Dental’s uniform rules and regulations; and (2) any Dentist who is a member or shareholder of a professional dental corporation or other entity that has entered into a corporate Delta Dental PPO Dentist agreement on behalf of its member, shareholder or employee Dentists and who abides by Delta Dental’s uniform rules and regulations.

“Delta Dental Premier Dentist” means (1) any Dentist who has entered into a Delta Dental Premier Dentist agreement with Delta Dental to provide or arrange for the provision of Dental Procedures to Policyholders and Covered Dependents and who abides by Delta Dental’s uniform rules and regulations; and (2) any Dentist who is a member or shareholder of a professional dental corporation or other entity that has entered into a corporate Delta Dental Premier Dentist agreement with Delta Dental on behalf of its member, shareholder or employee Dentists and who abides by Delta Dental’s uniform rules and regulations..

“Dental Procedure” means dental treatment provided by a Dentist or other individual licensed under state law to provide the treatment and reported to DDVA by the authorized responsible licensee using the Code on Dental Terminology (CDT).

“Dentist” means a person duly licensed to practice dentistry in the state or country in which the Dental Procedure is provided.

“Dependent” means a person other than the Policyholder who has satisfied the criteria for eligibility to enroll for coverage under this Policy.

“Effective Date” means the date shown as the Effective Date for coverage on the Application. The Effective Date of any Policy amendment, rider or endorsement will be shown on the amendment, rider or endorsement. If this Policy is renewed for additional Policy Periods, the Effective Date of any renewal Policy Period is the anniversary date.

“Emergency Care Allowance” means the amount up to \$50 that will be reimbursed to you for dental Emergencies treated by a Non-participating Dentist. You must provide us with proof of your payment to the Non-participating Dentist.



“Emergency” and “Urgent” mean a serious dental condition that manifests itself by acute symptoms of sufficient severity, including severe pain, which would lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate professional attention will likely result in any of the following: (a) serious jeopardy to the person’s health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child; (b) serious impairment to the person’s bodily functions; or (c) serious dysfunction of one or more of the person’s body organs or parts.

“Enrollee” means the Policyholder and the Policyholder’s Dependents who are entitled to coverage under the dental Policy and have properly enrolled.

“Fixed Patient Copayment” means the out-of-pocket amount paid by the Policyholder or Covered Dependent for each Dental Procedure that is a Benefit under this Policy.

“Grievance” means a complaint about quality of care or operational issues such as waiting times at provider offices, adequacy of participating provider facilities and network adequacy.

“Maximum Plan Allowance” or “MPA” means the amount we will allow for each covered Benefit based on the lowest of:

1. The fee that the Dentist submits to DDVA,
2. The most recent fee for the service the Dentist has on file with DDVA, or
3. The allowance that the Dentist has agreed to accept as full payment under the Participating Dentist agreement (less any Fixed Patient Copayments) for the covered Benefit that he or she provides to an Enrollee. In all cases, DDVA determines the plan allowance.

“Non-participating Dentist” means a Dentist who is not a member of Delta Dental’s PPO or Delta Dental Premier networks.

“Open Enrollment Period” means the last month of any Policy Period, during which time the Policyholder may add Dependents or remove Covered Dependents.

“Participating Dentist” means a Dentist who is a member of Delta Dental’s PPO or Delta Dental Premier networks.

“Policy” means this Policy, the schedule of dental Benefits, limitations, Fixed Patient Copayments, Policy exclusions any endorsements or riders to this Policy and the Application attached to this Policy.

“Policyholder” means a person who (a) has completed and signed the Application necessary for coverage under the Policy (b) has been accepted by DDVA for this Policy and (c) for whom the appropriate Premium has been paid.

“Policy Period” means the 12-month period beginning on the date your Policy becomes effective and ending on that same date 12 months later and any renewal 12-month period.

“PPO” means a preferred provider organization.

“Premium” means the total fee due for this Policy.

“Premium Period” means the period that you have chosen to pay Premiums. This Policy has a 12-month Policy Period, but you may choose to pay Premiums monthly, semiannually or annually.

PD.IFC#DEF [09.2010]



## COMMON DENTAL TERMINOLOGY

Listed below are definitions for commonly used dental terms.

“Abfraction” means when the bite is slightly off, it is common that one tooth may hit sooner than the rest. This causes undue stress on the involved teeth and they begin to flex. It is the continual flexing and stress that, over time, causes the enamel to separate from the inner tooth layer (dentin) forming the stress induced wear of the teeth.

“Abrasion” can occur as a result of overzealous tooth brushing, improper use of dental floss and toothpicks, or harmful oral habits such as chewing tobacco; biting on hard objects such as pens, pencils or pipe stems; opening hair pins with teeth; and biting fingernails. Abrasion also can be produced by the clasps of partial dentures.

“Analgesics” means pain medications.

“Amalgam/Amalgam Filling” a type of tooth filling made of silver and mercury.

“Anesthesia” substances used to remove the effects of pain. Generally 1 of 4 types: topical anesthesia, local anesthesia, IV sedation or general anesthesia.

“Anterior teeth” means the upper front teeth, tooth numbers 6-11; and/or the lower front teeth, tooth numbers 22-27.

“Attrition” means the wearing away of tooth structure as a result of excessive clenching and grinding.

“Bitewing X-rays” is similar to periapical X-rays except that only the crowns and part of the roots are seen for two (2) – three (3) adjacent teeth. Called bitewing due to the X-ray film holder, which provides a surface to bite down on and hold the X-ray securely in place.

“Bridge” is dental work that involves supporting a replacement tooth between two or more healthy teeth.

“Completion/Completion Date” is the actual date that the dental service is completed. For services such as crowns, removable and fixed partial dentures, it is the final date when the appliance is delivered and inserted in the mouth. For root canals, it is the date when the root canals are filled.

“Composite/Composite Filling” is an alternative to amalgam fillings. Composite fillings are made from a resin. They are naturally white, can easily be colored to match the surrounding teeth, and are relatively easy to install. Composite fillings are most generally used on front teeth.

“Conscious Sedation” is an induced state of sedation characterized by a minimally depressed consciousness such that the patient is able to continuously and independently maintain an airway, retain protective reflexes, and remain responsive to verbal commands and physical stimulation.

“Crowns” mean an artificial ‘top’ made of porcelain, composite, or metal that is cemented on top of damaged teeth.

“Dentures” means a set of artificial teeth.

“Endodontic” means the treatment of disease or injury of tooth pulp.

“Euphoric drugs” mean drugs that create a sense of well-being or elation.

“Fluoride” is a chemical known to strengthen tooth enamel making teeth less susceptible to decay.

“General Anesthesia” is a class of anesthesia substances that are inhaled as gases or injected intravenously. General anesthesia eliminates pain by rendering patients completely unconscious.

“Gingivectomy” is a procedure performed by a periodontist to remove diseased gum tissue.

“Habit-Breaking Appliances” is a dental appliance used to discourage harmful habits such as grinding and clenching teeth.

“Injections” typically mean an anesthetic delivered by a needle to cause either a numbing sensation or to induce general anesthesia.

“Impacted Tooth” means a tooth that is blocked by an adjacent tooth, bone, or soft tissue preventing it from erupting to the surface of the gum. Often times, impacted teeth must be surgically removed.

“Multistage/Multiple Appointment Procedures” mean dental services that require more than one appointment for their completion - such as crowns and root canals.

“Myofunctional Therapy” -is a structured, individualized therapy for retraining and restoring normal oral function such as:

- Elimination of damaging oral habits (thumb/finger sucking, nail biting, etc.).
- Establishment of normal biting, chewing, and swallowing patterns.

“Neuroleptic Anesthesia” means a class of anesthesia substance applied intravenously. The degree of anesthesia can be controlled from slight consciousness to total unconsciousness.

“Nitrous oxide” is- commonly known as laughing gas, when inhaled it produces a higher tolerance to pain and aids in the control of anxiety and apprehension.

“Occlusion” means the contact or biting relationship between teeth in the lower jaw and the teeth in the upper jaw.

“Orthodontic” means a branch of dentistry that deals with the correction of growth irregularities of the teeth and jaws.

“Periapical X-rays” are X-rays providing complete side views from the roots to the crowns of the teeth. Typically, a complete set consists of 14-24 films with each tooth appearing in two different films from two different angles.

“Periodontal” is referring to the gums

“Periodontal Disease” is an infection of the tissues that support the teeth.

“Personalization or Characterization” means a specialized technique requested by patients used to esthetically enhance the look of the teeth.

“Prosthetics” means dental implants or artificial teeth.

“Restorations” mean - fillings that replace tooth structure lost as the result of a cavity

“Root Canal” means a 3-step process required when the inner pulp of the tooth is irreversibly damaged. Step 1 involves removing all of the inner pulp of the tooth. Step 2 involves cleaning and smoothing the inside of the tooth. Step 3 involves filling the tooth with an inert material.

“Root Planing” means the procedure of scraping plaque off the teeth below the gum line or on the root of the tooth/teeth.

“Sealants” mean a substance applied to the biting surface of non-diseased teeth to protect them from decay.

“Space Maintainer” means a dental appliance used to maintain space in the mouth due to a tooth that has been prematurely lost before the permanent tooth has erupted.

“TMJ or Temporomandibular Joint Disorder” means the joint formed where the lower jawbone attaches to the head. TMJ refers to the general class of disorders affecting the bones and muscles of this region. Symptoms range from tenderness and swelling of the facial muscles and joint to headaches and neck and backaches. Often, a clicking or popping sound is heard when the jaw is opened or closed.

“Vertical Dimension” means the distance between two chosen points on the face above and below the mouth when the teeth are in a closed position.

PD.IFC#DTM [09.2010]

## **ELIGIBILITY**

**Only Virginia residents 18 or older or emancipated minors who are not covered under another policy or plan that covers Dental Procedures may purchase this Policy for themselves and/or their Dependents. This Policy does not contain an age limit for coverage of Dependents.**

The Policyholder may enroll for individual coverage or include Dependents who qualify based on the following:

1. Your lawful spouse;
2. Your domestic partner;
3. Your unmarried children including step and adopted children and children placed for adoption with you.

### **Coverage for a Newborn/Adopted Child**

A newborn child is covered at birth and coverage continues for 60 days. If you wish to continue coverage for the newborn, you must notify us in writing and pay an additional Premium within 60 days of the birth. If you adopt a child, coverage begins on the day the child is adopted, placed for adoption, or on the day of the final order granting adoption, whichever comes first. Changes in enrollment due to birth or adoption must be received by us within 60 days of the birth or adoption. If you do not notify us within 60 days of the birth or adoption, you may either add the child at the next renewal of your Policy or you may request a new Policy.

### **Adding or Removing Dependents**

You must apply during the Open Enrollment Period and be accepted to add any Dependent who does not qualify under the “Coverage for A Newborn/Adopted Child” section of this Policy. If we accept the Dependent for coverage and you pay any additional Premium required by us, the Covered Dependent will be covered under this Policy on the first day of the next Policy Period following the Open Enrollment Period.



## Notices

Notice to DDVA will be considered sufficient if mailed to DDVA's physical office or email address. Notices to you will be considered sufficient if mailed to your last known physical address or email address.

PD.IFC#ELG [09.2010]

## PREMIUMS, POLICY RENEWAL, GRACE PERIOD AND REINSTATEMENT

### Premiums

Your Premiums for this Policy will be shown on the Application. You are responsible for Premium payment even if another person has agreed to pay the Premium for you. The first Premium is due on the date that we accept your Application for coverage. You may choose to pay subsequent Premiums monthly, semiannually or annually. Subsequent Premiums are due on the first day of each Premium Period. Your Premium payments will be made by scheduled electronic charge to your credit card. You must pay the Premiums to us by the date that they are due.

DDVA may change the rates and/or Benefits under this Policy on the first day of any renewal Policy Period. DDVA will send you written notice of a rate change at least 30 days before the beginning of the renewal Policy Period. However, when this Policy's rate is increased for a renewal Policy Period, DDVA will send you a written notice at least 75 days before the renewal Policy Period. If any Benefits under your Policy are decreased, DDVA will send you written notice of the new Benefits at least 60 days before the renewal Policy Period. The rate change takes effect on the first day of the renewal Policy Period as described in the notice.

### Premium Due Date

This Policy is valid for the 12-month period starting with the Policy's Effective Date as shown in our records. After that, we will renew this Policy for additional Policy Periods if you remain eligible and pay the Premiums in accordance with the terms of this Policy. A renewal Policy Period's Premium due date is the first day of that renewal Policy Period.

### Initial Period of Coverage and Policy Renewal

This Policy's initial period of coverage is 12 months from the first day of the first month for which the Premium is paid. Each subsequent renewal period of coverage is for 12 months.

### Premium Grace Period

Unless you have notified us in advance that you wish to terminate your Policy, you will have a 31-day grace period to pay your Premium. If your bank account does not have sufficient funds to pay the monthly premium or your credit card is denied, and you have not notified us in advance that you wish to terminate your Policy, you will be charged an amount equal to two months premium on the next draft attempt. During this time, you will have a 31-day grace period to pay your Premium. Your policy stays in force during the grace period. In the event you do not bring your account up to date or supply a current credit card by the next draft attempt, any claims with a date of service after the grace period will be denied and you will be notified your Policy has been terminated effective the last day of the grace period.

### Policy Reinstatement

If we terminate this Policy for nonpayment of Premium and we accept a Premium payment without reservation within one (1) year after the date of termination, we will reinstate this Policy as of the date of our acceptance of the Premium.



Upon the reinstatement of this Policy, any claims you incurred for Dental Procedures, between the termination date and the Effective Date of the reinstatement are not covered and no Premium will be due for that period. In all other respects, the reinstated Policy will be treated as an uninterrupted contract subject to any provisions which are endorsed on or attached to the contract in connection with reinstatement and which are disclosed to you. We reserve the right to charge you a reasonable reinstatement fee.

PD.IFC#PRM [10.2012]

## **YOUR CHOICE OF DENTIST DELTA DENTAL PPO OR DELTA DENTAL PREMIER**

### **You Must Use a Delta Dental Premier or Delta Dental PPO Participating Dentist**

As a DDVA Policyholder, you are free to see any Delta Dental PPO or Delta Dental Premier Dentist as long as the Dentist is included in our national Delta Dental PPO or Delta Dental Premier dental networks. That includes Delta Dental PPO and Delta Dental Premier Dentists in any state where you may require dental treatment.

All Delta Dental Participating Dentists agree to accept DDVA's payment and any Fixed Patient Copayment as payment in full for covered Benefits. Our payment is made based on the Maximum Plan Allowance (MPA). The MPA is the amount we will allow for each covered Benefit based on the lowest of the fee that the Dentist submits to DDVA, the most recent fee for the service the Dentist has on file with DDVA or the allowance that the Dentist has agreed to accept as full payment under the Participating Dentist agreement (less any Fixed Patient Copayments) for the covered Benefit that he or she provides to an Enrollee. In all cases, DDVA determines the plan allowance.

**We will pay the Benefits under this Policy only if you or your Covered Dependents see a Dentist in either the Delta Dental PPO network or the Delta Dental Premier network.**

### **Emergency Care Allowance**

If a dental Emergency happens and you are not able to see a Delta Dental PPO or Delta Dental Premier Dentist, this Policy provides an Emergency Care Allowance of up to \$50 toward any amount you pay for Emergency relief of pain from a Non-participating Dentist. You must provide us with proof of your payment to the Non-participating Dentist before we will reimburse you up to \$50.

### **Information on Delta Dental Participating Dentists**

For information on Delta Dental PPO and Delta Dental Premier Dentists, visit Delta Dental's web site at [www.DeltaDentalCoversMe.com](http://www.DeltaDentalCoversMe.com) or call 888 899-3734

PD.IFC#DNT [09.2010]

## **SUMMARY OF DENTAL BENEFITS**

### **Copayment Information**

This Policy has a Fixed Patient Copayment for each Dental Procedure that is a Benefit under this Policy. DDVA will pay the balance of the contracted fee directly to the Delta Dental PPO or Delta Dental Premier Dentist after you or your Covered Dependent pays the Fixed Patient Copayment to the Dentist. All payments are based on the Maximum Plan Allowance established between Delta Dental and the Dentist for the Dental Procedure provided.



**Deductible**

This Policy does not require a deductible.

**Maximum**

This Policy does not include an annual or lifetime maximum benefit, although there are Benefit limitations and exclusions.

**Waiting Periods**

This Policy does not include waiting periods for any Benefits.

PD.IFC#SUM [09.2010]

## SCHEDULE OF DENTAL BENEFITS, LIMITATIONS AND FIXED PATIENT COPAYMENTS

Listed below are the covered Dental Procedures for which you have Fixed Patient Copayments under this Policy.

<b>Your Fixed Patient Copayment for Each Dental Procedure</b>	<b>Dental Benefit – Per Covered Person</b>
	<b>Diagnostic and Preventive Dental Procedures</b>
\$60	<p>Dental checkup once every six (6) months from the date of service. Dental checkup includes one or more of the following Dental Procedures provided during a dental visit.</p> <p>Examination or evaluation</p> <p>Any one of the following treatments</p> <ul style="list-style-type: none"> <li>• Cleaning for adults and children</li> <li>• Gross debridement (extensive cleaning (after a lapse in dental care))</li> <li>• Periodontal maintenance (specialized cleaning after periodontal therapy)</li> </ul> <p>Bitewing X-rays not more than seven (7) bitewing X-rays, all X-rays must be done on the same date of service</p> <p>Fluoride - topical application for children through age 14</p> <p>Gross debridement is a benefit once in a lifetime</p> <p>One or more of the above services within a 30 day period will incur one (1) copayment.</p>
\$0	Re-evaluation – limited, problem focused/post-operative office visit
\$0	Re-evaluation – post-operative office visit
\$54	Panoramic X-ray. Covered once every 5 years.
\$0	Intraoral – Single X-rays
\$0	Pulp vitality tests
\$0	Caries risk assessment and documentation, with a finding of low/moderate/high risk
\$32	Emergency /Problem focused evaluation
\$60	Full mouth series X-rays (includes a series of individual and bitewing X-rays). Covered once every 5 years. Shares frequency with Panoramic X-ray.

<b>Your Fixed Patient Copayment for Each Dental Procedure</b>	<b>Dental Benefit – Per Covered Person</b>
\$26	Sealants on the decay-free, biting surface of permanent molars, through age 14. One application per tooth every two (2) years. Copayment is per tooth.
\$30	Preventive resin restorations on the decay-free, biting surface of permanent molars, through age 14 One application per tooth every two (2) years.
\$26	Sealant repair – per tooth
\$90	Space maintainers for retaining space when a primary posterior tooth is prematurely lost for age 14 and under. Only one space maintainer is provided per missing tooth. Repair or replacement of a space maintainer is not a Benefit.
\$38	Re-cement or re-bond space maintainer
\$62	Removal of fixed space maintainer
<b>Restorative Dental Procedures</b>	
\$61	Amalgam (silver) restorations (fillings) on a single surface of the same tooth per visit are covered once every two (2) years.
\$74	Amalgam (silver) restorations (fillings) on two (2) surfaces of the same tooth per visit are covered once every two (2) years.
\$90	Amalgam (silver) restorations (fillings) on three (3) surfaces of the same tooth per visit are covered once every two (2) years.
\$90	Amalgam (silver) restorations (fillings) on four or more (4+) surfaces of the same tooth per visit are covered once every two (2) years.
\$70	Composite (tooth colored) restorations (fillings) on a single surface of the same anterior tooth per visit are covered once every two (2) years.
\$85	Composite (tooth colored) restorations (fillings) on two (2) surfaces of the same anterior tooth per visit are covered once every two (2) years.
\$90	Composite (tooth colored) restorations (fillings) on three (3) surfaces of the same anterior tooth per visit are covered once every two (2) years.
\$90	Composite (tooth colored) restorations (fillings) on four or more (4+) surfaces of the same anterior tooth per visit are covered once every two (2) years.
\$73	Composite (tooth colored) restorations (fillings) on a single surface of the same posterior tooth per visit are covered once every two (2) years.
\$90	Composite (tooth colored) restorations (fillings) on two (2) surfaces of the same posterior tooth per visit are covered once every two (2) years.
\$90	Composite (tooth colored) restorations (fillings) on three (3) surfaces of the same posterior tooth per visit are covered once every two (2) years.
\$90	Composite (tooth colored) restorations (fillings) on four or more (4+) surfaces of the same posterior tooth per visit are covered once every two (2) years.

<b>Your Fixed Patient Copayment for Each Dental Procedure</b>	<b>Dental Benefit – Per Covered Person</b>
\$90	Resin-based crown on the same surface of the same anterior tooth per visit are covered once every two (2) years.
	<p><b>Crowns are a Benefit when teeth are broken down by decay and can no longer be restored adequately with a filling material.</b></p> <ul style="list-style-type: none"> <li>• <b>Coverage for replacing a defective existing crown is provided once every seven (7) years, whether or not DDVA paid for the original crown.</b></li> </ul> <p><b>Crowns for Covered Dependents under age twelve (12) are not covered Benefits.</b></p> <p><b>Only one crown for each covered person every 12 months.</b></p>
\$277	Crown-resin-based composite (indirect)
\$493	Crown-3/4 resin-based composite (indirect)
\$536	Crown-resin with high noble metal
\$456	Crown-resin with predominantly base metal
\$507	Crown-resin with noble metal
\$597	Crown-porcelain/ceramic
\$575	Crown-porcelain fused to high noble metal
\$547	Crown-porcelain fused to predominantly base metal
\$555	Crown-porcelain fused to noble metal
\$558	Crown-3/4 cast high noble metal
\$521	Crown-3/4 cast predominantly base metal
\$538	Crown-3/4 cast noble metal
\$538	Crown-3/4 porcelain/ceramic
\$576	Crown-full cast high noble metal
\$520	Crown-full cast predominantly base metal
\$538	Crown-full cast noble metal
\$565	Crown-titanium
\$50	Re-cement or re-bond indirectly fabricated or prefabricated post and core; only one recementation is provided per tooth
\$44	Re-cement or re-bond crown; only one recementation is provided per tooth
\$60	Crown repair
\$73	Reattachment of tooth fragment, incisal edge or cusp
\$60	Additional procedures to construct a new crown under existing partial denture framework

<b>Your Fixed Patient Copayment for Each Dental Procedure</b>	<b>Dental Benefit – Per Covered Person</b>
\$90	Prefabricated porcelain/ceramic, stainless steel and resin crowns are covered only on primary teeth. Replacement is covered once every two (2) years, whether or not DDVA paid for the original crown.
\$0	Sedative filling
\$0	Interim therapeutic restoration-primary dentition. Once per primary tooth.
\$0	Core buildup, including any pins when required.
\$0	Pin retention – per tooth, in addition to restoration
\$0	Post and core in addition to crown, indirectly fabricated.
\$0	Prefabricated post and core in addition to crown.
\$0	Post removal
	<b>Periodontic Dental Procedures</b>
\$231	Mesial/distal wedge procedure (when not performed in conjunction with surgical procedures in the same area); once in three (3) years per site.
\$200	Gingivectomy or gingivoplasty-four or more contiguous teeth or tooth bounded spaces per quadrant; once per quadrant every three (3) years.
\$159	Gingivectomy or gingivoplasty-one to three contiguous teeth or tooth bounded spaces per quadrant. Once per quadrant every three (3) years.
\$159	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth
\$200	Crown exposure – four or more contiguous teeth or bounded tooth spaces per quadrant. Once per quadrant every three (3) years.
\$176	Crown exposure – one to three teeth or bounded tooth spaces per quadrant. Once per quadrant every three (3) years.
\$200	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant. Once per quadrant every three (3) years.
\$192	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant. Once per quadrant every three (3) years.
\$200	Apically positioned flap
\$374	Clinical crown lengthening
\$479	Osseous surgery (including elevation of a full thickness flap and closure)- four or more contiguous teeth or tooth bounded spaces per quadrant. Once per quadrant every three (3) years.

<b>Your Fixed Patient Copayment for Each Dental Procedure</b>	<b>Dental Benefit – Per Covered Person</b>
\$275	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant. Once per quadrant every three (3) years.
\$0	Bone replacement graft – retained natural tooth
\$0	Biologic materials to aid in soft and osseous tissue regeneration
\$0	Guided tissue regeneration – resorbable barrier, per site
\$0	Guided tissue regeneration – non-resorbable barrier, per site (includes membrane removal)
\$361	Pedicle soft tissue graft procedure; once per site every three (3) years.
\$392	Autogenous connective tissue graft procedure – first tooth, implant or edentulous tooth position in graft
\$235	Autogenous connective tissue graft procedure – each additional contiguous tooth, implant, or edentulous tooth position in same graft site
\$379	Non-autogenous connective tissue graft procedure – first tooth, implant or edentulous tooth position in graft
\$227	Non-autogenous connective tissue graft procedure – each additional contiguous tooth, implant or edentulous tooth position in same graft site
\$472	Combined connective tissue and double pedicle graft, per tooth
\$337	Free soft tissue graft procedure – first tooth, implant or edentulous tooth position in graft; once per site every three (3) years.
\$200	Free soft tissue graft procedure – each additional contiguous tooth, implant or edentulous tooth position in same graft site
\$120	Scaling and root planing - four or more teeth per quadrant; once per quadrant every two (2) years.
\$71	Scaling and root planing - one to three teeth per quadrant; once per quadrant every two (2) years.
\$0	Unscheduled dressing change (by someone other than treating dentist or their staff)
	<b>Endodontic Dental Procedures</b>
\$107	Apexification - initial visit
\$104	Apexification – interim medication replacement
\$120	Apexification – final visit
\$86	Pulpotomy is a Benefit only on primary teeth, excluding final restoration.
\$90	Pulpal therapy is a Benefit only on primary teeth, excluding final restoration.
\$79	Pulpal debridement is a Benefit on primary and permanent teeth.
\$82	Partial pulpotomy for apexogenesis is a Benefit of permanent teeth.
\$0	Treatment of root canal obstruction; nonsurgical access



<b>Your Fixed Patient Copayment for Each Dental Procedure</b>	<b>Dental Benefit – Per Covered Person</b>
\$0	Internal root repair of perforation defects
\$110	Retrograde filling
\$120	Root amputation or hemisection (surgery on tooth roots), excluding final restoration.
	<p><b>Root canal therapy including retreatment, surgical endodontics and apicoectomy limited to treatment of two (2) teeth in a Policy Period, excluding final restoration.</b></p> <ul style="list-style-type: none"> <li>• Root canal therapy and apicoectomy; limited to once per tooth every two (2) years, whether or not DDVA paid for the original service.</li> </ul>
\$348	Anterior tooth root canal (excluding final restoration)
\$391	Premolar tooth root canal (excluding final restoration)
\$500	Molar tooth root canal (excluding final restoration)
\$334	Retreatment of previous root canal therapy – anterior
\$447	Retreatment of previous root canal therapy – premolar
\$500	Retreatment of previous root canal therapy – molar
\$200	Periradicular surgery without apicoectomy
\$275	Apicoectomy – anterior
\$365	Apicoectomy – premolar (first root)
\$391	Apicoectomy – molar (first root)
\$0	Apicoectomy (each additional root)
	<b>Prosthetic/Prosthodontic/Implant Dental Procedures</b>
	<p><b>This Policy covers one prosthetic appliance each Policy Period (16 years or older). A prosthetic appliance is any of the following:</b></p> <ul style="list-style-type: none"> <li>• Fixed bridge (up to three 3 units)</li> <li>• Removable complete or partial denture</li> <li>• Surgical implant placement, implant abutment, implant crown</li> </ul> <p><b>Replacement of a defective existing fixed bridge or partial/complete denture or implant is covered once every seven (7) years, whether or not DDVA paid for the original prosthetic appliance.</b></p>
\$120	Implant removal
\$144	Remove broken implant retaining screw
\$60	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaced, without flap entry and closure
\$200	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of exposed implant surfaces, including flap entry and closure.

<b>Your Fixed Patient Copayment for Each Dental Procedure</b>	<b>Dental Benefit – Per Covered Person</b>
\$700	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant, and surface cleaning includes surface cleaning of the exposed implant surfaces including flap entry and closure
\$60	Implant maintenance, repair implant supported prosthesis, repair implant abutment.
\$700	Replacement of an abutment and implant supported single crown on an implant; covered only after seven (7) years from date previous crown was delivered, whether or not DDVA paid for the original crown.
\$2500 per implant	Surgical placement of implant body (includes implant, mini implant, crown and abutment); one (1) implant per site up to a maximum of two (2) implant bodies per quadrant of the mouth per lifetime. Replacement of one (1) missing tooth either by single implant or three (3) unit bridge is covered per Policy Period. 16 years of age or older.
	<b>Prosthetics, including fixed bridgework (to replace 1 missing tooth, partial dentures or complete dentures to replace missing permanent teeth).</b> <b>Prosthetics for Covered Dependents under age sixteen (16) are not covered Benefits.</b> <b>When multiple teeth are being replaced, coverage is limited to a partial or complete denture.</b> <b>Inlay and onlay fixed bridge abutments are not Benefits.</b>
\$700	Complete denture – maxillary
\$700	Complete denture – mandibular
\$700	Immediate denture - maxillary
\$700	Immediate denture - mandibular
\$568	Maxillary partial denture-resin base (including any conventional clasps, rests and teeth)
\$568	Mandibular partial denture-resin base (including any conventional clasps, rests and teeth)
\$700	Maxillary partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
\$568	Mandibular partial denture- cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
\$597	Immediate maxillary partial denture-resin base (including any conventional clasps, rests and teeth)
\$700	Immediate mandibular partial denture-resin base (including any conventional clasps, rests and teeth)
\$700	Immediate maxillary partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)

<b>Your Fixed Patient Copayment for Each Dental Procedure</b>	<b>Dental Benefit – Per Covered Person</b>
\$700	Immediate mandibular partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
\$700	Maxillary partial denture-flexible base (including any clasps, rests and teeth)
\$700	Mandibular partial denture-flexible base (including any clasps, rests and teeth)
\$499	Removable unilateral partial denture-one piece cast metal (including clasps and teeth)
\$440	Pontic-indirect resin based composite
\$553	Pontic-cast high noble metal
\$523	Pontic cast predominantly base metal
\$537	Pontic-cast noble metal
\$553	Pontic-titanium
\$553	Pontic-porcelain fused to high noble metal
\$534	Pontic porcelain fused to predominantly base metal
\$544	Pontic-porcelain fused to noble metal
\$558	Pontic-porcelain/ceramic
\$520	Pontic-resin with high noble metal
\$491	Pontic-resin with predominantly base metal
\$495	Pontic-resin with noble metal
\$249	Retainer-cast metal for resin bonded fixed prosthesis
\$385	Retainer-porcelain/ceramic for resin bonded fixed prosthesis
\$249	Resin retainer-for resin bonded fixed prosthesis
\$474	Retainer crown-indirect resin based composite
\$547	Retainer crown-resin with high noble metal
\$521	Retainer crown-resin with predominantly base metal
\$544	Retainer crown-resin with noble metal
\$597	Retainer crown-porcelain/ceramic
\$575	Retainer crown-porcelain fused to high noble metal
\$547	Retainer crown-porcelain fused to predominantly base metal
\$555	Retainer crown-porcelain fused to noble metal
\$568	Retainer crown-3/4 cast high noble metal
\$546	Retainer crown-3/4 cast predominantly base metal
\$560	Retainer crown-3/4 cast noble metal

<b>Your Fixed Patient Copayment for Each Dental Procedure</b>	<b>Dental Benefit – Per Covered Person</b>
\$560	Retainer crown-3/4 porcelain/ceramic
\$554	Retainer crown-full cast high noble metal
\$520	Retainer crown-full cast predominantly base metal
\$531	Retainer crown-full cast noble metal
\$570	Retainer crown-titanium
\$120	Reline or rebase complete or partial removable dentures once in a 12 month period.
\$97	Repair broken complete denture base, mandibular
\$97	Repair broken complete denture base, maxillary
\$80	Replace missing or broken teeth - complete denture (each tooth)
\$89	Repair resin partial denture base, mandibular
\$89	Repair resin partial denture base, maxillary
\$120	Repair cast partial framework, mandibular
\$120	Repair cast partial framework, maxillary
\$115	Repair or replace broken clasp-per tooth
\$80	Replace broken teeth-per tooth
\$95	Add tooth to existing partial denture
\$120	Add clasp to existing partial denture-per tooth
\$120	Replace all teeth and acrylic on cast metal framework (maxillary)
\$120	Replace all teeth and acrylic on cast metal framework (mandibular)
\$39	Adjustment to complete or partial removable dentures and tissue conditioning. Adjustments to complete and partial dentures are limited to one (1) adjustments per denture in a 12 month period (after six (6) months has elapsed since initial treatment).
\$58	Fixed partial denture sectioning. Covered only if a portion of the fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment.
\$60	Tissue conditioning
\$63	Re-cement or re-bond fixed partial denture
\$120	Fixed partial denture repair necessitated by restorative material failure
<b>Surgical Dental Procedures</b>	
\$63	Removal of coronal remnants
\$79	Extraction, erupted tooth or exposed root
\$123	Extraction, erupted tooth requiring removal of bone and/or section of tooth, and including elevation of mucoperiosteal flap if indicated

<b>Your Fixed Patient Copayment for Each Dental Procedure</b>	<b>Dental Benefit – Per Covered Person</b>
\$147	Removal of impacted tooth – soft tissue
\$188	Removal of impacted tooth – partially bony
\$200	Removal of impacted tooth – completely bony
\$200	Removal of impacted tooth – completely bony, with unusual surgical complications
\$127	Removal of residual tooth roots (cutting procedure)
\$152	Coronectomy
	<b>All Other Dental Procedures</b>
\$0	Emergency treatment to relieve pain; once on the same date. Evaluation is not considered relief of pain
\$105	Deep sedation/general anesthesia – first 15 minutes
\$79	Deep sedation/general anesthesia – each subsequent 15 minute increment
\$90	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes
\$68	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment
	<b>Dental Procedures from a Non-participating Dentist</b>
Patient pays entire charge	Emergency relief of pain from a Non-participating Dentist is reimbursed up to \$50 upon proof of Policyholder's or Covered Dependent's payment.

PD.IFC#SB [02.2018]

## OPTIONAL PROCEDURES

We will pay the Maximum Plan Allowance for the least expensive Dental Procedure that is adequate to restore the tooth or dental arch to contour and function, but only if that Dental Procedure is a Benefit under this Policy. You, or your Covered Dependent, will be responsible for the remainder of the Dentist's fee if a more expensive Dental Procedure is selected. For each Benefit, the Fixed Patient Copayment will apply regardless of which Dental Procedure is selected.

PD.IFC#OPT [09.2010]

## POLICY EXCLUSIONS

This Policy does not include coverage for any of the following:

1. Expenses for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.
2. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion including restoration of tooth structure lost from attrition, abrasion, abfraction, corrosion, or erosion and restorations for misalignment of teeth.
3. Multistage procedures are reported and benefited upon completion. The completion date for removable prosthetic appliances is the date of final insertion. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns is the final cementation date regardless of the type of cement utilized. The completion date for root canal therapy is the date the canals are permanently filled. The completion date must be inserted on the claim and any date other than a completion date must be accurately described (e.g., "prep date").
4. General anesthesia/intravenous (deep) sedation, except as specified by this Policy.
5. Crowns for Covered Dependents under age 12.
6. Prosthetics for Covered Dependents under age 16.
7. All orthodontic and related services.
8. Services rendered for injuries or conditions which are compensable under Workmen's Compensation or Employer's Liability laws; services which are provided by any federal or state or provincial government agency, or are provided without cost to the Policyholder or Covered Dependent by any municipality, county or political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable eligible dental benefits contained in this Policy.
9. Application of desensitizing agents
10. This Policy does not cover services or supplies whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation.
11. Prescription drugs.
12. Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections.
13. Hospitalization charges and any additional fees charged by the Dentist for hospital treatment.
14. Charges for consultation or second opinion.
15. Charges for broken appointments.
16. Patient management problems.
17. Charges for completion of claim forms.
18. Habit-breaking appliances.
19. Non-surgical and surgical TMJ services or supplies.
20. Oral hygiene instructions, tobacco and nutritional counseling.
21. Services performed or items furnished for any conditions, disease, ailment or injury occurring while the Policyholder or Covered Dependent is on active duty during military service, or for services or items provided under the laws of the United States of America or of any state of the United States or any foreign country or of any political subdivision of any of the foregoing.

22. Dental services performed or started (for multiple appointment procedures) prior to the date the Policyholder or Covered Dependent became eligible for such services under this Policy.
23. Dental services performed or completed (for multiple appointment procedures) after the termination date for the Policyholder or Covered Dependent.
24. Laboratory tests and/or laboratory examinations.
25. Any service or item which is determined by Delta Dental not to be a dentally necessary service or item for the treatment of the Policyholder's or Covered Dependent's condition, disease or injury. Delta Dental reserves the right to review the Policyholder's or Covered Dependent's dental records, including necessary radiographs, photographs and models to determine whether a service or item is necessary.
26. Periodontal charting is considered a component of the diagnosis and treatment of periodontal disease and is not a chargeable procedure.
27. Expenses for treatment provided by someone other than a Delta Dental Premier and/or Delta Dental PPO Participating Dentist, including Dental Procedures provided by a licensed dental hygienist employed and acting under the supervision of someone other than a Delta Dental Premier and/or Delta Dental PPO Dentist.
28. Covered services that are not performed by or under the direction of a licensed Dentist or other Delta Dental approved licensed professional. A "licensed Dentist" means a licensed Dentist legally authorized to practice dentistry at the time and in the place services are performed.
29. Expenses for replacement of a lost, missing or stolen prosthetic device.
30. Expenses for any duplicate prosthetic device or any other duplicate appliance.
31. Expenses for services or supplies for which no charge is made that the Policyholder or Covered Dependent is legally obligated to pay or for which no charge would be made in the absence of dental expense coverage.
32. Expenses for services to the extent that such services, or benefits for or because of such services, are otherwise provided under any other plan or policy.
33. Inlays and onlays are not Benefits.
34. Repair or replacement of a space maintainer is not a Benefit.
35. Cases in which the treating Dentist has indicated a satisfactory result cannot be obtained or there is little or no likelihood of a successful and lasting result based on the patient's dental condition.
36. Any other service not specifically included in this Policy as Benefits.

PD.IFC#EXC [09.2010]

## **PREDETERMINATION, CLAIMS, APPEALS AND GRIEVANCES**

### **Predetermination**

A predetermination is not an authorization for services but a notification of covered dental Benefits available at the time the predetermination is made and is not a guarantee of payment. If your dental care will be extensive, you may ask your Dentist to complete and submit a request for an estimate, sometimes called a "predetermination of benefits." This will allow you to know in advance what procedures may be covered, the amount we may pay and your expected financial responsibility.

A predetermination of Benefits is valid for 12 months but in the event your Benefits are terminated and you are no longer eligible, the predetermination is voided. We will make payments based on your available Benefits, limitations as described in your Policy and the current plan provisions when the treatment is provided.



## **FILING CLAIMS**

### **To File a Claim**

To file a claim with us, simply present your identification card to the receptionist at your Dentist's office. Claims should be filed with us within 90 days after you receive dental services or supplies. Dental Procedures are considered for Benefits if they are incurred during the Policy term and a claim is filed within 12 months from the date of service.

We will make available to you notice of our claims processing, called an Explanation of Benefits, within 30 days of our receipt of the claim, unless special circumstances require more time. The Explanation of Benefits explains our payment or our reason(s) for nonpayment of your claim. If a claim is denied because of incomplete information, the Explanation of Benefits will indicate what additional information is needed.

### **Dental Procedure Incurred**

A Dental Procedure is incurred on the date it is completed. Dental Procedures are considered for Benefits if they are incurred during the Policy Period and a claim is filed within 12 months after the date on which the Dental Procedure is incurred. You, or your Covered Dependent, will be responsible for payment for any Dental Procedures that are completed after termination of your or your Covered Dependent's coverage.

### **Claims Review and Appeals Procedures**

You have the right to appeal a denied claim or adverse benefit determination. Adverse benefit determinations are decisions DDVA makes that result in denial, reduction or termination of a Benefit or amount paid. It also means a decision not to provide a Benefit or service. Adverse benefit determinations can result from one or more of the following:

The individual is not eligible to participate in the DDVA plan; or we determine that a Benefit or service is not a covered Benefit because:

- It is not included in the list of covered Benefits,
- It is specifically excluded,
- A Benefit limitation under the DDVA plan has been reached, or
- Is not necessary or customary for the diagnosis or treatment of your condition (Dental Necessity).



We will provide you with written notices of adverse benefit determinations within the periods shown in the following chart.

Type of Claim	Claim Procedures and Appeal Process	
<p><b>Post-Service Health Claim</b> A claim that is a request for payment under DDVA for covered services already received.</p>	Step 1:	DDVA has 30 days after receiving your initial claim to notify you of the benefit determination. DDVA can take a one-time extension of 15 days for matters beyond our control. We must notify you within the initial 30-day period of the extension and the reason for the extension.
	Step 2:	For a denied claim, you have 180 days to appeal the initial adverse benefit determination and 60 days to appeal any subsequent determinations.
	Step 3:	DDVA has a two level appeal process. We have 30 days after receiving your appeal to notify you of the appeal decision and 30 additional days for the 2nd level appeal. Both levels of appeal must be completed within the 60-day deadline.
<p><b>Improper or Incomplete Claim</b> A claim that does not include enough information for us to make a determination.</p>	Step 1:	DDVA has 30 days after receiving your claim to notify you of its decision. DDVA can take a one-time extension of 15 days if we are unable to make a benefit determination due to insufficient information received with the claim. After receipt of the initial claim, DDVA must notify you within 15 days if an extension is necessary.
	Step 2:	You have 45 days after receiving the extension notice to provide additional information or complete the claim. If the requested information is not received, your claim will be denied.
	Step 3:	For a denied claim, you have 180 days to appeal the initial adverse benefit determination and 60 days to appeal any subsequent determinations.
	Step 4:	DDVA has a two level appeal process. We have 30 days after receiving your 1 <sup>st</sup> level appeal to notify you of the appeal decision and 30 additional days for the 2 <sup>nd</sup> level appeal. Both levels of appeal must be completed within the 60-day deadline.

## Notice to Claimant of Adverse Benefit Determinations

We will provide written or electronic notification of any denial or adverse benefit determination.

### 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.



## Appeals of Adverse Benefit Determinations

Customer Service Representatives are available during regular business hours to answer your questions. You can reach us at 888-899-3734 or the toll-free number on the bottom of your DDVA ID card. Individuals with special hearing requirements may contact us by calling the AT&T TTY/TDD Service Center at 877-287-9039 and ask to be connected to the DDVA Customer Service line, 888-899-3734. If a matter cannot be resolved to your satisfaction based on a telephone call, our internal appeals process is available to you. We have a two level appeal process.

You or your authorized representative must file the appeal in writing and explain why you believe our decision was incorrect. Your appeal should include the following information:

- Name, address and daytime telephone number;
- The member number and group number (as shown on the ID Card);
- The patient's name, address and daytime telephone number; and
- The date of service, name and address of the Dentist who provided the service.

You may submit written comments, documents, records and other information relating to the claim even though we did not consider the information when making the initial decision. 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.

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 if dental judgment is required. The dental care professional whom we consult for the appeal will not be the person 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 their advice in reaching our adverse decision.

Please send your request for appeal of an adverse benefit determination to:

Delta Dental of Virginia  
Attn: Appeal Review  
PO Box 103  
Stevens Point, WI 54481-0103

## Grievances

DDVA would like Enrollees to be completely satisfied with the dental care and services they receive but recognizes that there are times an Enrollee may have questions, concerns or complaints. If you are dissatisfied with the service received from us or that of a Participating Dentist, you may file a grievance with us. A grievance is a complaint about quality of care or operational issues such as waiting times at provider offices, adequacy of participating provider facilities and network adequacy.

Please send your grievance to:

Delta Dental of Virginia  
Attn: Grievance Review  
PO Box 103  
Stevens Point, WI 54481-0103



## External Assistance

If you are unable to contact or obtain satisfaction from DDVA, you may contact the following state agencies for assistance:

<b>Address:</b>	Office of Licensure and Certification Virginia Department of Health 9960 Mayland Drive, Suite 401 Richmond, Virginia 23233-1463
<b>Telephone Toll-Free:</b>	800-955-1819
<b>Richmond:</b>	804- 367-2106
<b>Fax:</b>	804-527-4503
<b>E-Mail:</b>	mchip@vdh.virginia.gov
<b>Web Page:</b>	<a href="http://www.vdh.virginia.gov">http://www.vdh.virginia.gov</a>
<b>Address:</b>	Consumer Service Section Virginia Bureau of Insurance PO Box 1157 Richmond, Virginia 23218
<b>Telephone Toll-Free:</b>	800-552-7945 (Virginia) 877-310-6560 (National)
<b>Richmond:</b>	804-371-9691
<b>Fax:</b>	804-371-9944
<b>E-Mail:</b>	bureauofinsurance@scc.virginia.gov
<b>Web Page:</b>	<a href="http://www.scc.virginia.gov/division/boi">http://www.scc.virginia.gov/division/boi</a>

If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided that have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance.

<b>Address:</b>	Office of Managed Care Ombudsman Virginia Bureau of Insurance P.O. Box 1157 Richmond, Virginia 23218
<b>Telephone Toll-Free:</b>	877-310-6560
<b>Richmond:</b>	804-371-9032
<b>E-Mail:</b>	ombudsman@scc.virginia.gov
<b>Web Page:</b>	<a href="http://www.scc.virginia.gov">http://www.scc.virginia.gov</a>

PD.IFC#CLM [09.2010]

## TERMINATION OF THIS POLICY

### Mid-Term Termination by Policyholder

This Policy has a Policy Period of 12 months. Your Policy may be terminated for you or your Dependents during the Policy Period only for the following reasons:



1. You or any Covered Dependent become covered under a group dental plan offered by your employer.
2. Either you die or a Covered Dependents dies. If you die, any Dependents covered under your Policy may choose to continue the Policy. If a Covered Dependent dies, you may terminate coverage under the Policy for that Covered Dependent.
3. Your Dentist ceases to be a provider under both our Delta Dental PPO and Delta Dental Premier networks.
4. You or a Covered Dependent enters full-time United States military service. If you enter full-time military service, you may choose to terminate the Policy or to continue the Policy for your Dependents. If a Covered Dependent enters military service, you may terminate coverage under the Policy for that Covered Dependent.
5. Your Dependent's marital status changes.

You must notify us within 30 days of the date that any of the above events occur and provide us with sufficient proof of the occurrence. If you comply with the notification and proof requirements of termination, we will make an equitable refund of any unused Premium to you.

### **Mid-Term Termination by DDVA**

We may terminate the Policy during the Policy Period only for the following reasons:

1. You fail to pay the Premium when due.
2. You or a Covered Dependent commits fraud or intentional material misrepresentation of a material fact, as determined by us.
3. You or a Covered Dependent permits a person not authorized to use your/his/her ID card, which shall be considered fraudulent conduct.
4. You move outside of Virginia
5. You or a Covered Dependent fails to comply with the Policy provisions, as determined by us.

If we terminate this Policy for any reason before any period for which Premium has been paid ends, we will make an equitable refund of any unused Premium to you.

### **Nonrenewal**

You may decline renewal of this Policy by sending written notice to us (either electronically or by U.S. Postal Service) in advance of the Policy's anniversary date. If you send such notice, this Policy will end as of the last day of the Policy Period. We may choose not to renew this Policy by sending you written notice (either electronically or by U.S. Postal Service) at least 60 days in advance of the Policy's anniversary date. If we send you such notice, this Policy will end as of the last day of the Policy Period.

### **Effective Date of Termination**

All insurance for you and/or your Covered Dependents will cease on the date this Policy is terminated. This Policy will terminate on the earliest of:

1. In the event of nonpayment of Premium, the last day of the grace period.
2. The last day of the month in which a qualifying event occurs.
3. The last day of the prior Policy Period if either we or you decline to renew this Policy.
4. The date of your death if there are no Covered Dependents who wish to continue the Policy.
5. The date of death of any Covered Dependent, but only for the Covered Dependent.



6. If you engage in fraudulent conduct or furnish us with fraudulent or misleading material information relating to your Application for coverage then we may terminate your coverage back to its original Effective Date. If we terminate your policy back to its original Effective Date, we will return the Premium that you paid us minus any claims that we paid. If the claims that we paid exceed the Premium that you paid, you may be responsible to pay us the difference.
7. If you move out of Virginia, on the last date of the Policy Period during which you moved.
8. The last day of the month in which you become eligible for group dental coverage.

PD.IFC#TRM [10.2012]

## **GENERAL PROVISIONS**

### **Delta Dental of Virginia's Liability**

We are not responsible for the actual care you receive from any person. This Policy does not give anyone any claim, right or cause of action against us based on what a provider of dental care, services or supplies does or does not do.

### **Notices**

Except as otherwise provided in this policy, any notice sent to DDVA must be sent in writing (either electronically or by U.S. Postal Service) and is considered delivered when delivery is sent to us at the email address shown below or when it is in person or when sent by registered or certified United States mail return receipt requested, proper postage prepaid and properly addressed to:

Delta Dental of Virginia  
PO Box 103  
Stevens Point, WI 54481-0103  
Email: [www.DeltaDentalCoversMe.com](http://www.DeltaDentalCoversMe.com)

### **Governing Law**

This Policy shall be governed by the laws of the Commonwealth of Virginia. With the exception of the appeal process outlined in this Policy, you agree that all legal actions will be filed in the state and federal courts located in the County of Roanoke, Commonwealth of Virginia.

As a Managed Care Health Insurance Plan operating in the Commonwealth of Virginia, DDVA 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).

***THIS POLICY CONSTITUTES THE ENTIRE AGREEMENT AND UNDERSTANDING BETWEEN YOU AND DELTA DENTAL OF VIRGINIA, INCLUDING POLICY SCHEDULES, AMENDMENTS OR RIDERS MADE A PART OF THE DENTAL POLICY***

### **Nonwaiver and Severability**

No delay or failure by us to exercise any remedy or right accruing to it hereunder shall impair any such right or be construed to be a waiver of any such remedy or rights, nor shall it affect any subsequent remedies or rights that we may have hereunder, whether or not the circumstances are the same.



## Entire Contract Changes

The entire contract of insurance between you and us is comprised of this Policy, the Application, schedule of dental benefits, exclusions, limitations and Fixed Patient Copayments and all endorsements and riders, if any.

No oral statements by any person shall modify or otherwise affect the Benefits, limitations, conditions or exclusions of this Policy, convey or void any coverage, increase or reduce Benefits under the Policy, including the schedule of dental benefits, limitations and Fixed Patient Copayments or be used in the prosecution or defense of a claim under this Policy.

PD.IFC#GEN [09.2010]

## IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact us at the following address and telephone number:

Delta Dental of Virginia  
PO Box 103  
Stevens Point, WI 54481-0103  
Telephone: 888-899-3734  
TTY/TDD: 800-855-2880

We recommend that you familiarize yourself with our grievance procedure and make use of it before taking any other action.

If you have been unable to contact or obtain satisfaction from DDVA, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

<b>Address:</b>	Consumer Service Section Virginia Bureau of Insurance PO Box 1157 Richmond, Virginia 23218
<b>Telephone Toll-Free:</b>	800-552-7945 (Virginia only) 877-310-6560 (National)
<b>Richmond:</b>	804-371-9691
<b>Fax:</b>	804-371-9944
<b>Email:</b>	<a href="mailto:bureauofinsurance@scc.virginia.gov">bureauofinsurance@scc.virginia.gov</a>
<b>Web Page:</b>	<a href="http://www.scc.virginia.gov/division/boi">http://www.scc.virginia.gov/division/boi</a>

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting DDVA or the Bureau of Insurance, have your policy number available.

PD.IFC#IMP [01.2017]



# Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

Delta Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Delta Dental does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Jennifer Morrison, Compliance Manager, 2801 Hoover Road, Stevens Point, WI 54481, Phone: 715-344-6087, TTY: 877-287-9039, Fax: 715-344-9058, [jmorrison@deltadentalwi.com](mailto:jmorrison@deltadentalwi.com).

If you believe that Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Jennifer Morrison, Compliance Manager, 2801 Hoover Road, Stevens Point, WI 54481, Phone: 715-344-6087, TTY: 877-287-9039, Fax: 715-344-9058, [jmorrison@deltadentalwi.com](mailto:jmorrison@deltadentalwi.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Jennifer Morrison, Compliance Manager, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.