

# Delta Dental Individual and Family Basic Plan Insurance Policy

## 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, delivered in Virginia and administered by Delta Dental of Wisconsin and/or its subsidiary, Wyssta Services. 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 and Limitations” section for the list of covered Benefits for which you have Coinsurance payments.

Claims are processed based upon a Maximum Plan Allowance, which may be less than the provider’s billed charge. Please see the “Choosing a 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 (declaration 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 must notify us in writing within ten (10) days. We will void the Policy and refund the Premium, less any claim payments issued.

## Effective Date and Policy Term

The Effective Date of this Policy is the effective date shown on the declaration page of your Policy. This Policy will remain in effect for 12 months from the Effective Date. 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. **It continually renews unless we choose not to renew your coverage or you tell us you no longer want this coverage.** Premium rates may change at renewal. We will notify you of any Premium change at least 30 days before the beginning of the renewal Policy Period. However, when this Policy's rate or any deductible 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 rate and 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.**

**www.DeltaDentalCoversMe.com:** You may make address or payment method 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 via email.

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



Frank Lucia  
President and CEO

PD.ICP#WLM [01.2015]



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## 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.

“**Benefit Waiting Period**” is the period of time that must pass after enrolling under the Policy before an Enrollee can start receiving covered Benefits.

“**Coinsurance**” is the portion of the dental services the Enrollee is responsible for paying. It is usually a percentage of the Maximum Plan Allowance the Enrollee pays directly to the Dentist for covered Benefits after meeting any applicable deductible.

“**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.

“**Deductible**” is a fixed dollar amount the Enrollee is responsible to pay before Delta Dental will begin covering benefits.

“**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 Spouse, Children (married or unmarried) or a dependent child who is incapable of self-support because of a physical or mental incapacity that began prior the age limit requirements or coverage for individual that is court ordered. A Dependent is 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”** 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.

**“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 allowance that the Dentist has agreed to accept as full payment under the Participating Dentist agreement (less any applicable Deductibles and Coinsurances) 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, 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.ICP#DEF [06.2012]

## 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.ICP#DTM [06.2012]

## **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 legal children, married or unmarried, up to the end of the month when they turn age 26,
3. A dependent child who is incapable of self-support because of a physical or mental incapacity that began prior the age limit requirements, or
4. Coverage for individual that is court ordered.

### **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 dependent will be covered under this Policy on the first day of the next Policy 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.ICP#ELG [06.2012]

## **PREMIUMS, POLICY RENEWAL, GRACE PERIOD AND REINSTATEMENT**

### **Premiums**

Your Premiums for this Policy are shown on the declaration page. 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 either scheduled electronic charge to your credit card or an Electronic Funds Transfer (EFT) from your bank account. You must pay the Premiums to us by the date that they are due. If the charge is declined on the due date, we will notify you, and you may pay the premium. If at the end of the grace period, your account is still overdue, we will terminate coverage for all persons insured under this Policy.

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 or any deductible 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 rate and 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.

This Policy is valid for the 12-month period starting with the Policy’s Effective Date as shown on the declaration page. After that, we may 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 30-day grace period to pay your Premium. Your Policy stays in force during the grace period. If you do not pay your Premium within the grace period, this Policy will automatically terminate on the last day of the grace period.

## Policy Reinstatement

If we terminate this Policy for nonpayment of Premium you must wait 24 months before you are eligible for another Policy.

PD.ICP#PRM [01.2015]

## CHOOSING A DENTIST

**You can choose any Dentist to provide dental services. However, the Dentist you choose will affect the total amount you pay under this policy.**

Delta Dental has a Maximum Plan Allowance (MPA) for benefits, which represents the highest amount Delta Dental will pay for dental procedures. Delta Dental PPO and Delta Dental Premier Dentists will not charge you more than the MPA for any covered procedure.

Delta Dental PPO and Delta Dental Premier participating Dentists have agreed to accept our maximum plan allowance as payment in full for your covered benefits. You are responsible for any deductible and/or coinsurance that may apply. You may visit an out-of-network Dentist; however, your out-of-pocket costs will likely be higher since the Dentist may balance-bill you for additional charges above our maximum plan allowance, in addition to your deductible and coinsurance.

If a claim is denied due to a benefit limitation and the service was provided by a Delta Dental participating Dentist, that Dentist may be required to provide the additional service at no charge to the patient. If the service was performed by a non-participating Dentist, that Dentist may charge the patient for the additional service which will not be covered by Delta Dental.

## 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.ICP#DNT [06.2012]

## SUMMARY OF DENTAL BENEFITS

### Deductible

The deductible for dental procedures is \$0.00 for you and each covered dependent. This Plan has a per person, per office visit co-payment of \$15, which is an amount of money that you must pay each time you visit the dentist. You are responsible for paying the \$15 per visit co-payment directly to your provider.

The maximum total benefit that can be paid in any benefit accumulation period is \$1,000 for you and each covered dependent.

This Policy doesn't include an orthodontic benefit.

This Policy provides benefits according to the coverage percentage listed in the following chart, after the deductible (if any) is paid.

In the following chart, if the coverage percentage shown is 50 Delta Dental will pay 50% of the amount Delta Dental allows, after any deductibles are paid. In this case, the coinsurance (the amount the patient must pay) is 50%.

Any Benefit Waiting Periods will be waived for you and any covered dependent if you were covered under another comprehensive dental-insurance plan for at least 12 months before you enrolled in this plan and only if there was no more than a 63-day gap between your previous plan and this plan. (You may have to supply information about your previous plan to make sure you qualify for waived waiting periods.)

PD.ICP#SUM [03.2019]

## SCHEDULE OF DENTAL BENEFITS, LIMITATIONS AND COINSURANCE

<b>Diagnostic, Preventive and Emergency Dental Procedures</b>	
<b>Coverage Percentage</b>	<b>What is covered (for each person covered under the plan)</b>
100%	Examination or evaluation, once every 6 months
100%	Simple cleanings, once every 6 months
100%	Bitewing X-rays, 1 set every 12 months, limited to 4 films
50%	Fluoride (for children through age 14), once every 12 months
50%	Full-mouth X-rays once every 5 years (a series of individual X-rays or a panoramic X-ray)
50%	Sealants on decay-free, biting surface of permanent molars, 1 sealant per tooth per lifetime, for ages 14 and under
50%	Space maintainers when a primary tooth is prematurely lost
50%	Emergency (palliative) treatment to relieve pain
50%	Emergency evaluation once every 12 months
<b>All Other Dental Procedures</b> (a 6-month waiting period* applies to all of these procedures)	

50%	Composite (tooth-colored) fillings on front teeth, Amalgam (silver-colored) fillings on back teeth Replacing an existing filling is covered once every 2 years.
50%	Non-surgical extractions
*Refer to the “Waiting Period” section for more information on waiting periods.	

PD.ICP#SB [01.2019]

### OPTIONAL PROCEDURES

We will pay the Maximum Plan Allowance for the least expensive Dental Procedure that is necessary 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 applicable Coinsurance will apply regardless of which Dental Procedure is selected.

PD.ICP#OPT [06.2012]

### SCHEDULE OF 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. Oral surgery, including surgical extractions.
6. Crowns for covered Enrollees under age 12.
7. Prosthetics for covered Enrollees under age 16.
8. All orthodontic and related services.
9. 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.

10. Application of desensitizing agents
11. 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 or is not in accordance with generally accepted standards of dental practice.
12. Prescription drugs.
13. Pain relievers such as nitrous oxide, conscious sedation, euphoric drugs or injections.
14. Hospitalization charges and any additional fees charged by the Dentist for hospital treatment.
15. Consultations and second opinions.
16. Charges for consultation or second opinion.
17. Charges for broken appointments.
18. Charges for patient management problems.
19. Charges for completion of claim forms.
20. Habit-breaking appliances.
21. Temporomandibular joint (TMJ) services or supplies.
22. Oral hygiene instructions, tobacco and nutritional counseling.
23. 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.
24. Any dental services to treat injuries or diseases caused by any form of civil disobedience or criminal act, or any injuries intentionally inflicted.
25. Dental services performed or started prior to the date the Policyholder or Covered Dependent became eligible for such services under this Policy.
26. Dental services performed or started after the termination date for the Policyholder or Covered Dependent.
27. Laboratory tests and/or laboratory examinations.
28. 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.
29. Periodontal charting is considered a component of the diagnosis and treatment of periodontal disease and is not a chargeable procedure.
30. 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.
31. Expenses for replacement of a lost, missing or stolen prosthetic device.
32. Expenses for any duplicate prosthetic device or any other duplicate appliance.
33. 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.
34. Services covered or provided under any other plan or policy.

35. Inlays and onlays are not Benefits.
36. Repair or replacement of a space maintainer is not a Benefit.
37. 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.
38. Claims not submitted within 15 months of the date of service.
39. Any other service not specifically included in this Policy as Benefits.
40. Services billed under multiple procedure codes which Delta Dental, in its sole discretion, determines that the service was either a component part of or inclusive of the more comprehensive or primary procedure code. This exclusion is subject to any and all internal and external appeal available to you. Delta Dental bases its payment on the Plan Allowance for the underlying component codes.
41. If a claim is denied due to a benefit limitation and the service was provided by a Delta Dental participating Dentist, that Dentist may be required to provide the additional service at no charge to the patient. If the service was performed by a non-participating Dentist, that Dentist may charge the patient for the additional service which will not be covered by Delta Dental.

PD. ICP#EXC [06.2012]

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

### **Predetermination**

A predetermination is not an authorization for services nor a guarantee of payment but a notification of covered dental Benefits available at the time the predetermination is made. 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, your continued eligibility under the Policy, the current plan provisions when the treatment is provided and all other terms of this Policy.

### **Filing Claims**

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.

Participating Dentists file all claims to us directly; however, some Non-participating Dentists may not file a claim on your behalf. If that is the case, please mail a copy of the itemized claim form to:

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

Find a listing of Delta Dental Participating Dentists nationwide at [www.DeltaDentalCoversMe.com](http://www.DeltaDentalCoversMe.com), or call 888-899-3734.

### **Covered Benefits by Non-Participating Dentists:**

Our payments are based on a percentage of the set dollar amounts outlined in the **Schedule of Dental Benefits**. Non-Participating Dentists have not agreed to accept Delta Dental's payment as full payment. After Delta Dental pays its portion of the bill, you pay the rest, up to the Dentist's total charge for Dental Services received. You are also responsible for any Deductibles and Coinsurances. Unless Virginia law requires otherwise, we pay you directly for any Covered Benefits.

Any payment DDVA makes directly to you is your responsibility to remit to your Non-Participating Dentist.

### **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	
<b>Post-Service Health Claim</b> A claim that is a request for payment under DDVA for covered services already received.	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.
<b>Improper or Incomplete Claim</b> A claim that does not include enough information for us to make a determination.	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:

**Address:** Office of Licensure and Certification  
Virginia Department of Health  
9960 Mayland Drive, Suite 401  
Richmond, Virginia 23233-1463

**Telephone Toll-Free:** 800-955-1819  
**Richmond:** 804- 367-2106  
**Fax:** 804-527-4503  
**E-Mail:** [mchip@vdh.virginia.gov](mailto:mchip@vdh.virginia.gov)  
**Web Page:** <http://www.vdh.virginia.gov>

**Address:** Consumer Service Section  
Virginia Bureau of Insurance  
PO Box 1157  
Richmond, Virginia 23218

**Telephone:** 800-552-7945 (Virginia only)  
877-310-6560 (Toll-Free, National)  
804-371-9691 (Richmond)  
**Fax:** 804-371-9944  
**E-Mail:** [bureauofinsurance@scc.virginia.gov](mailto:bureauofinsurance@scc.virginia.gov)  
**Web Page:** <http://www.scc.virginia.gov/division/boi>

If you have any questions regarding an appeal or grievances 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.



**Address:** Office of Managed Care Ombudsman  
Virginia Bureau of Insurance  
P.O. Box 1157  
Richmond, Virginia 23218

**Telephone:** 877-310-6560 (Toll-Free)  
804-371-9032 (Richmond)

**E-Mail:** [ombudsman@scc.virginia.gov](mailto:ombudsman@scc.virginia.gov)

**Web Page:** <http://www.scc.virginia.gov>

PD.ICP#CLM [06.2012]

## **TERMINATION OF THIS POLICY**

### **Termination by Policyholder**

When you purchase this policy you are committing to keeping it for at least 12 months. If you cancel this policy early for any reason other than those listed below, you will have to wait 24 months before we will issue you any other individual dental policy.

You can only terminate this policy before the end of the 12-month period without penalty of the requirement to wait 24 months before you can obtain another individual policy from DDVA for the following reasons:

1. You become covered under a group dental plan offered at work. If anyone else covered under this policy becomes covered under a group plan, they may be terminated without terminating the entire policy. If you or your dependent becomes covered under another individual dental plan, you will still be obligated to continue this plan.
2. You die. In that instance, the policy may terminate or anyone else covered under your policy who meets the eligibility standards may choose to continue the policy. If a covered person other than you dies, you can terminate their coverage without terminating the entire policy.
3. You enter into full-time United States military service. In that instance, the policy may terminate or anyone else covered under your policy who meets the eligibility standards may choose to continue the policy. If a covered person other than you enters military service, you may terminate their coverage without terminating the entire policy.

If any of the above events occur, and you want us to terminate your policy or coverage for a dependent under your policy, you must tell us in writing within 30 days of the events and send us proof of the event. Once you do, we will refund any unused premium paid.

## Termination by DDVA

We may terminate the Policy 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 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 refund your unused Premium.

## 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 prior Policy Period if either we or you don't renew this Policy.
3. The date of your death if there are no Covered Dependents who wish to continue the Policy.
4. The date of death of any Covered Dependent, but only for the Covered Dependent.
5. 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.
6. If you move out of Virginia, on the last date of the Policy Period during which you moved.
7. The last day of the month in which you become eligible for group dental coverage.
8. The end of the month following 30 days written notice from you to terminate this Policy.

PD.ICP#TRM [06.2012]

## 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  
Website: [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***

### Non-waiver 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, the declaration page, schedule of dental benefits, exclusions and limitations 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 and limitations or be used in the prosecution or defense of a claim under this Policy.

PD.ICP#GEN [06.2012]

## 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:

**Address:** Consumer Service Section  
Virginia Bureau of Insurance  
PO Box 1157  
Richmond, Virginia 23218

**Telephone:** 800-552-7945 (Virginia only)  
877-310-6560 (National)  
804-371-9691 (Richmond)

**Fax:** 804-371-9944

**Email:** [bureauofinsurance@scc.virginia.gov](mailto:bureauofinsurance@scc.virginia.gov)

**Web Page:** <http://www.scc.virginia.gov/division/boi>

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.ICP#IMP [01.2017]



## Nondiscrimination and Language Assistance Services

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 and service to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact Delta Dental’s Customer Service at: 1(888)899-3734, TTY: 711.

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: Compliance Manager, PO Box 103 Stevens Point, WI 54481, Ph: 1(715)344-6087, TTY: 711, Fx: (715) 344-9058 or by email at: [compliance\\_wi@deltadentalwi.com](mailto:compliance_wi@deltadentalwi.com). You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our 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, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

<b>Shqip (Albanian)</b>	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-899-3734 (TTY: 711).
<b>አማርኛ (Amharic)</b>	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-888-899-3734 (መስማት ለተሳናቸው፡ 711)።
<b>العربية (Arabic)</b>	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 711-(رقم هاتف الصم والبكم: 1-888-899-3734).
<b>Ikirundi (Bantu – Kirundi)</b>	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-888-899-3734 (TTY: 711).
<b>বাংলা (Bengali)</b>	লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নি:খরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-৮৮৮-৮৯৯-৩৭৩৪ (TTY: ১-৭১১)।
<b>မြန်မာစကား (Burmese)</b>	သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-888-899-3734 (TTY: သို့ ခေါ်ဆိုပါ။)



<b>ខ្មែរ (Cambodian)</b>	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-888-899-3734 (TTY: 711)។
<b>tsalagi gawonihisdi (Cherokee)</b>	Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 1 – 888-899-3734 (TTY: 711)
<b>繁體中文 (Chinese)</b>	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-899-3734 (TTY: 711)
<b>Oroomiffa (Oromo)</b>	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-899-3734 (TTY: 711).
<b>Français (French)</b>	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-899-3734 (ATS : 711).
<b>Kreyòl Ayisyen (French Creole)</b>	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-899-3734 (TTY: 711).
<b>Deutsch (German)</b>	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-899-3734 (TTY: 711).
<b>λληνικά (Greek)</b>	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-888-899-3734 (TTY: 711).
<b>ગુજરાતી (Gujarati)</b>	સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-899-3734 (TTY: 711).
<b>हिंदी (Hindi)</b>	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-899-3734 (TTY: 711) पर कॉल करें।
<b>Hmoob (Hmong)</b>	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-899-3734 (TTY: 711).
<b>Bahasa Indonesia (Indonesian)</b>	PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi 1-888-899-3734 (TTY: 711).
<b>Italiano (Italian)</b>	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-899-3734 (TTY: 711).
<b>日本語 (Japanese)</b>	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-899-3734 (TTY:711) まで、お電話にてご連絡ください
<b>한국어 (Korean)</b>	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-899-3734 (TTY: 711)번으로 전화해 주십시오.
<b>èdè Yorùbá (Yoruba)</b>	AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-888-899-3734 (TTY: 711).

Igbo asusu (Ibo)	Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-888-899-3734 (TTY: 711).
ພາສາລາວ (Lao)	ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຂອງພວກເຮົາສາມາດຊ່ວຍທ່ານພາສາ, ໂດຍບໍ່ຄ່າ ຫຼື ຄ່າເບີ, ຈົນເຖິງ ສິ່ງທີ່ທ່ານຕ້ອງການ. ໂທ 1-888-899-3734 (TTY: 711).
Diné Bizaad (Navajo)	D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go <b>Diné Bizaad</b> , saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 1-888-899-3734 (TTY: 711.)
नेपाली (Nepali)	ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-899-3734 (टिपिवाङ्क: 711) ।
Thuɔŋjaŋ (Nilotic – Dinka)	<b>PIŊ KENE:</b> Na ye jam në Thuɔŋjaŋ, ke kuony yenë koc waar thook atö kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1-888-899-3734 (TTY: 711)
Deutsch (Pennsylvania Dutch)	Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprouch. Ruf selli Nummer uff: Call 1-888-899-3734 (TTY: 711).
فارسی (Farsi)	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-899-3734 (TTY: 711) تماس بگیرید.
Polski (Polish)	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-899-3734 (TTY: 711).
Português (Portuguese)	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-899-3734 (TTY: 711).
ਪੰਜਾਬੀ (Punjabi)	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-899-3734 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-899-3734 (телетайп: 711).
Srpsko-hrvatski (Serbo-Croatian)	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-899-3734 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).
Español (Spanish)	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-899-3734 (TTY: 711).
Kiswahili (Swahili)	KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-888-899-3734 (TTY: 711).
ܐܘܪܝܝܢܐ (Assyrian)	ܐܘܪܝܝܢܐ: ܟܘܢ ܢܘܨܫܠܝܬܐ ܟܘܢ ܐܘܪܝܝܢܐ, ܡܘܥܝܢܐ ܟܘܢ ܘܢܘܨܫܠܝܬܐ ܢܘܨܫܠܝܬܐ ܢܘܨܫܠܝܬܐ ܢܘܨܫܠܝܬܐ. ܕܘܫܘܢܐ ܘܕܘܫܘܢܐ ܘܕܘܫܘܢܐ ܘܕܘܫܘܢܐ 1-888-899-3734 (TTY: 711) ܕܘܫܘܢܐ.
Tagalog (Tagalog – Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-899-3734 (TTY: 711).

<b>ภาษาไทย (Thai)</b>	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-899-3734 (TTY: 711).
<b>اُردُو (Urdu)</b>	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں -1-888-899-3734 (TTY: 711).
<b>Українська (Ukrainian)</b>	УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-899-3734 (телетайп: 711).
<b>Tiếng Việt (Vietnamese)</b>	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-899-3734 (TTY: 711).

PD.ICP#IMP [01.2019]