DELTA DENTAL®

Delta Dental of Virginia dental plans

Network Name	Delta Dental PPO Plus Premier™		
Plan name	Passive Employer paid 5-200; voluntary 5-300 employees	aXcess™ 25† Employer paid 2-49	aXcess™ 50** Employer paid 2-4
Deductible†	$50 annual per person; limited to three per family	$50 lifetime, per person	
Annual maximum benefit	Choice of $1,000, $1,250, or $2,500 per person	$2,000 per person	
Networks	PPO | Premier | OON	PPO | Premier | OON	
Type I — Diagnostic and Preventive Care	*No deductible. No benefit waiting period.*	*No deductible. No benefit waiting period.*	
Exams and cleanings	100% | 100% | 100%	100% | 100% | 100%	
Fluoride applications	100% | 100% | 100%	100% | 100% | 100%	
Sealants	100% | 100% | 100%	100% | 100% | 100%	
X-rays	100% | 100% | 100%	100% | 100% | 100%	
Type II — Basic Dental Care	*Deductible applies. No benefit waiting period.*	*Deductible applies. No benefit waiting period.*	
Composite fillings	80% | 80% | 80%	80% | 80% | 80%	
Simple extractions	80% | 80% | 80%	80% | 80% | 80%	
Denture repair and recementation of crowns and bridges	80% | 80% | 80%	80% | 80% | 80%	
Endodontic/periodontic/ complex oral surgery	80% | 80% | 80%		
Type III — Major Dental Care	**Optional** — *Deductible applies. No benefit waiting period.*	*Deductible applies. No benefit waiting period.*	
Endodontic/periodontic/ complex oral surgery		25% | 25% | 25%	50% | 50% | 50%
Crowns	50% | 50% | 50%	25% | 25% | 25%	50% | 50% | 50%
Prosthodontics/ dentures/bridges	50% | 50% | 50%	25% | 25% | 25%	50% | 50% | 50%
Implants	50% | 50% | 50%	25% | 25% | 25%	50% | 50% | 50%
Type IV — Orthodontic Benefits	**Optional*** — *No deductible. No benefit waiting periods for contributory; 12-month waiting period applies to voluntary.*	*No deductible. No benefit waiting period.*	
Orthodontic services	50% | 50% | 50%	25% | 25% | 25%	N/A
Lifetime maximum benefit	Match annual max (up to $2,500)	$500	N/A

OON = Out-of-Network. NOTE: All small business plans include Right Start 4 Kids®, which provides 100% coverage for children up to age 13 for diagnostic and preventive and basic and major services, with no deductible, when visiting an in-network dentist. See plan provisions for exclusions and limitations.
*Orthodontic coverage is available to groups with 10 or more employees enrolled. **aXcess 50 is only available to groups with two to four eligible employees.
†When orthodontic services are elected orthodontic services apply to all covered members (adults and children).

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Dental plan underwriting guidelines

1. Coverage is offered on an employer-sponsored basis only. An employer/employee relationship must exist; individuals who are not employees are not eligible for coverage. If the primary subscriber enrollment is fewer than five, dependents/spouse of the primary subscriber may not enroll in a separate contract to increase the group size. For example, an individual and spouse may not enroll as two separate "subscriber" contracts, or as "subscriber/child(ren)" contracts, even if both are employees. Association groups require Delta Dental Underwriting Department approval.

2. Virginia-based businesses enrolling 2-99 employees who are engaged in bona fide trade or commerce in the commonwealth are eligible. However, the following organizations are not eligible for coverage: fraternal organizations, sales groups, independent contractors and membership groups. A North American Industry Classification System (NAICS) number is required for rating purposes.

3. All Voluntary groups of up to 300 eligible employees are rated together in a product pool. Groups with more than 300 eligible employees require Delta Dental Underwriting Department approval.

4. All plans utilize a five-tier rating structure consisting of subscriber, subscriber/spouse, subscriber/child(ren) and family. No other rating structures are available.

5. For rate guarantee, please refer to the rate page included in your quote documents. Underwriting Guidelines include, but are not limited to, minimum enrollment and employee participation levels. Coverage begins the first day of the month after the contract is issued. Please submit the group's data at least 15 days prior to the desired start date.

6. The eligibility waiting period for newly hired employees will be the first day of the month following 90 days from the date of hire. Coverage ends on the last day of the month that the member ceases to be eligible under the group dental plan. If a group's existing medical plan benefits have a different eligibility requirement, then Delta Dental will match it for this coverage (for example: first day of the month following the date of hire).

7. Employees and their dependents NOT included in the initial enrollment may be eligible for coverage on the first day of the month following a qualifying event such as marriage or divorce, death of a spouse, birth of a child, legal adoption or loss of other group coverage. Otherwise, they may enroll only during the group's annual open enrollment period.

8. If an employee covered under one of the Voluntary plans drops coverage, he/she is not eligible to re-enroll until the second group open enrollment period after the date of termination. In addition, if the employee cancels after less than one year of enrollment, he/she must remit the balance of the first year's premium before re-enrolling.

9. Group acceptance is not guaranteed. Approval of coverage is contingent upon underwriting acceptance and verification of employee participation. Groups with more than 20% of their employees residing outside of Virginia require special underwriting approval and may require a premium adjustment.

10. Delta Dental coverage must be the only employer-sponsored group dental plan offered to the group's employees.

11. Children are eligible for coverage until the end of the month following their 26th birthday under subscriber/child(ren) or family plans.

12. Premiums are based on the number of employees enrolled. For example, a group of 52 eligible employees that only enrolls 39 employees will be rated in the 10-49 pool.

13. Waiting periods may be waived for initial enrollees if the group is replacing a prior group dental plan that covered these services for at least 12 consecutive months. Please submit dated, current carrier group bills and benefit description with the application. Anything less than 12 months of prior coverage will not be considered toward waiting period waivers for initial enrollees. Employees hired after initial enrollment require proof of credible coverage to receive credit for a waiting period for both Employer-Paid and Voluntary plans.

14. Please check with your Delta Dental sales representative for questions and availability of dual option dental plans. Contributory groups enrolling 10-99 employees or Voluntary groups enrolling 10-299 may elect a High/Low Benefit Plan at standard pool rates subject to the following conditions: (1) The Low Plan and High Plan must either both include orthodontic coverage or exclude orthodontic coverage, (2) If waiting periods are elected, they must be applied to both plans and remain the same (0, 6 or 12 months), (3) Endodontics, periodontics and oral surgery must remain in the same category on both plans (4) If posterior composite coverage is elected, it must be applied to both plans (5) If orthodontic coverage is elected on both plans, the lifetime maximum and coverage level (child only or adult/child coverage) must remain consistent on both plans and (6) A minimum of 25% of those enrolling must elect the High Plan. Deductibles, predefined coinsurance levels and benefit maximums may vary from the Low Plan to the High Plan; the combined participation level and employer contribution level must still meet Delta Dental's requirement for this product. All employees must elect a plan at their initial enrollment and may only change plans during the group's annual open enrollment period (unless a qualifying event has occurred). **A dual-option scenario with a High Plan covering orthodontics and a Low Plan that does not cover orthodontic coverage can be achieved under parameters determined on a case-by-case basis by Underwriting. If this**

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Dental plan underwriting guidelines (cont.)

scenario is desired or if any questions arise concerning the dual-option availability, please contact your Delta Dental sales representative.

15. Major services are optional coverage for all Delta Dental traditional products except aXcess™ and Delta Dental EPO™. If major benefits are selected, diagnostic and preventive/basic coverage are required.

16. Orthodontic services are optional coverage for all Delta Dental traditional products except aXcess 25™ and Delta Dental EPO™. Orthodontic services are not covered under aXcess 50. A minimum enrollment of 10 is required for all Delta Dental products except aXcess 25 or an EPO plan. The minimum enrollment for aXcess 25 is two. There is no minimum enrollment requirement for an EPO plan. Orthodontic benefits are available to all enrollees, if selected. If orthodontic benefits are selected, diagnostic and preventive, basic and major coverage are required.

Benefit Limitations

Annual deductible — group choice of deductible. Limit of three per family per contract year (deductible does not apply to Type I or Type IV services). The aXcess™ product features a lifetime deductible. Under aXcess, once a covered member meets the required deductible, future covered services will be paid as though there is no deductible for the lifetime of the contract.

- Oral exams and cleanings are covered twice each 12-consecutive month period.
- Sealants: only for noncarious, nonrestored first and second permanent molars for enrollees under the age of 16, one application per tooth.
- Bitewing radiographic images (X-rays) are covered once each 12-consecutive month period, limited to four films in one visit.
- Full mouth (panelipse) X-rays: limit of one every three years for Employer-Paid plans, one every five years for Voluntary (Employee-Paid) plans. Full mouth X-ray includes bitewing X-rays. Panoramic X-ray in conjunction with any other X-ray is considered a full mouth X-ray.
- Space maintainers, not including distal shoe space maintainers, are limited to once per quadrant or arch per lifetime for enrollees under the age of 14.
- Distal shoe space maintainers are limited to once per quadrant per lifetime for enrollees under the age of nine.
- Fluoride applications are limited to once each 12-consecutive month period for enrollees under the age of 19.
- Full mouth debridement is limited to once in a lifetime and is only a covered benefit when an enrollee has not had a cleaning or scaling and root planing within 36 months of the full mouth debridement.
- Amalgam and composite fillings: except as otherwise provided in the plan documents, composite (white) fillings limited to upper six and lower six anterior (front) teeth; once in a 24-month period per tooth, per surface.
- Stainless steel crowns: limited to primary/baby teeth for enrollees under the age of 14.
- Denture repair and recementation of crowns, bridges and dentures: limited to once in a 12-month period after six months from initial placement.
- Endodontic services/root canal therapy: retreatment only after 24 months from initial root canal therapy treatment and is limited to once in a lifetime.
- Periodontic services: Periodontal cleaning is considered a regular cleaning and is subject to the benefit limits for regular cleanings. Limitations of 24 to 36 months apply based on services rendered
- Crowns: once per tooth every 60 months, and only when an existing crown cannot be rendered serviceable. Benefit is available only when the tooth is damaged by decay or fractured to the point that it cannot be restored by an amalgam or composite restoration. Crowns are limited to enrollees age 12 and older.
- Prosthodontics/dentures/bridges not related to an implant: once every 60 months, and only when an existing prosthesis cannot be rendered serviceable. Temporary prosthetic devices are not a separate benefit. Any charge for these devices is included in the fee for the permanent device. Fixed bridges or removable partials are limited to enrollees age 16 and older.
- Implants and implant-supported prosthetics are limited to once in a lifetime per site and are also limited to two per quadrant and four per arch, with a maximum of eight for full mouth reconstruction for enrollees age 16 and older.
- Adjustment, maintenance or cleaning of a maxillofacial prosthetic appliance is limited to once per year.
- Orthodontic benefits are limited to enrollees age five and older.

MaxOver™

Eligibility for MaxOver benefits is determined three months after the end of the plan benefit period. Any claims processed or adjusted after a member's annual MaxOver eligibility is determined will not alter the individual's eligibility for the benefit. Orthodontic benefits (if covered) are excluded from the MaxOver program. MaxOver benefits cease to be available when a member's coverage under the group contract terminates.

Exclusions

The following are not covered unless specifically identified as a covered benefit in Delta Dental's plan documents:

- Services or supplies that are not dental services; also services not specifically listed as covered in the group's Schedule of Benefits.
- Services or treatment provided by someone other than a licensed dentist or a qualified licensed dental hygienist working under the supervision of a dentist.

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Dental plan underwriting guidelines (cont.)

- A dental service that Delta Dental, at its sole discretion (subject to any and all internal and external appeals available to you), determines is not necessary or customary for the diagnosis or treatment of your condition. In making this determination, Delta Dental will take into account generally accepted dental practice standards based on the dental services provided. In addition, each covered benefit must demonstrate dental necessity. Dental necessity is determined in accordance with generally accepted standards of dentistry.
- Dental services for injuries or conditions that may be covered under workers compensation, similar employer liability laws or other medical plan coverage; also, benefits or services that are available under any federal or state government program (subject to the rules and regulations of those programs) or from any charitable foundation or similar entity.
- Dental services for the diagnosis or treatment of illnesses, injuries or other conditions for which you are eligible for coverage under your hospital, medical/surgical or major medical plan.
- Dental services started or rendered before the date enrolled under the group contract. Also, except as otherwise noted, benefits for a course of treatment that began before you are enrolled under the group contract.
- Except as otherwise provided for in the plan documents, dental services provided after the date you are no longer enrolled or eligible for coverage.
- Except as otherwise provided for in the plan documents, prescription and nonprescription drugs, pre-medications, preventive control programs, oral hygiene instructions and relative analgesia.
- General anesthesia when fewer than three teeth will be routinely extracted during the same office visit.
- Splinting or devices used to support, protect or immobilize oral structures that have loosened or been reimplanted, fractured or traumatized.
- Charges for inpatient or outpatient hospital services and any additional fee that the dentist may charge for treating a patient in a hospital, nursing home or similar facility.
- Charges to complete a claim form, copy records or respond to Delta Dental's requests for information.
- Charges for failure to keep a scheduled appointment.
- Charges for consultations in person, by phone or by other electronic means.
- Charges for X-ray interpretation.
- Dental services to the extent that benefits are available or would have been available if you had enrolled, applied for or maintained eligibility under Title XVIII of the Social Security Act (Medicare), including any amendments or other changes to that Act.
- Complimentary services or dental services for which you would not be obligated to pay in the absence of the coverage under this plan or any similar coverage.
- Services or treatment provided to an immediate family member by the treating dentist. This would include a dentist's parent, spouse or child.
- Dental services and supplies for the replacement device or repeat treatment of lost, misplaced or stolen prosthetic devices, including space maintainers, bridges and dentures (among other devices).
- Dental services or other services that Delta Dental determines are for correcting congenital malformations; also, cosmetic surgery or dentistry for cosmetic purposes.
- Replacement of congenitally missing teeth by dental implant, fixed or removable prosthesis, whether the result of a medical diagnosis, including, but not limited to, hereditary ectodermal dysplasia, or not related to a medical diagnosis.
- Experimental or investigative dental procedures, services and supplies, as well as services and/or procedures due to complications thereof, which, in the judgment of Delta Dental: (a) are in a trial stage, (b) are not in accordance with generally accepted standards of dental practice or (c) have not yet been shown to be consistently effective for the diagnosis or treatment of the enrollee's condition.
- Dental services for restoring tooth structure lost from wear (abrasion, erosion, attrition or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion or for stabilizing the teeth. Such services include, but are not limited to, equilibration and periodontal splinting.
- Dental services, procedures and supplies needed because of harmful habits. An example of a harmful habit includes clenching or grinding of the teeth.
- Services billed under multiple dental service procedure codes, which Delta Dental, at its sole discretion (subject to any and all internal and external appeals available to you), determines should have been billed under a single, more comprehensive dental service procedure code. Delta Dental bases its payment on the negotiated fee for the more comprehensive code, not on the negotiated fee for the underlying component codes.
- Services billed under a dental service procedure code that Delta Dental, at its sole discretion (subject to any and all internal and external appeals available to you), determines should have been billed under a code that more accurately describes the dental service. Delta Dental bases its payment on its determination of the more accurate dental service code.
- Amounts assessed on dental services and/or supplies by state or local regulation.
- Amounts that exceed the negotiated fee as agreed to by the dentist for covered benefits.