



Delta Dental of Pennsylvania

MEBA Medical and Benefits Plan

Combined Evidence of Coverage and Disclosure Form



deltadentalins.com

Group No. 11472

Effective Date: 12/1/2016



EVIDENCE OF COVERAGE

Delta Dental of Pennsylvania

Administrative Offices

One Delta Drive

Mechanicsburg, PA 17055-6999

(717) 766-8500 Toll free: (800) 932-0783

TTY/TDD: (888) 373-3582

www.deltadentalins.com

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INTRODUCTION

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

Using This Evidence of Coverage

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

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

Contact Us

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

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

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

| |
|--|
| <p style="text-align: center;">Delta Dental One Delta Drive Mechanicsburg, PA 17055</p> |
|--|

SELECTING YOUR DENTIST**Free Choice of Dentist**

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

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

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

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

Referrals to Specialists

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

If you are diagnosed with a condition or disease that requires a specialist and no specialist who is a participating dentist has the specialized dental training and expertise to treat your condition or disease or Delta Dental can not provide reasonable access to a specialist who is a participating dentist without unreasonable delay or travel, you may be referred or consult a specialist who is not a participating dentist on your own. For purposes of calculating any deductible, co-payment amount or co-insurance payable by you, he will be considered a Premier Participating Dentist for your treatment. Remember, if the dentist is not a Premier dentist, you may be required to pay all of the treatment cost at the time of service and submit a claim to Delta Dental for reimbursement.

Locating a Delta Dental Participating Dentist

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

- You may access information about the plan through our web site at www.deltadentalins.com. This web site includes a dentist search function allowing you to locate Delta Dental participating dentists by location, specialty and network type; or
- You may also call Delta Dental and one of our representatives will assist you. He/she can provide you with information regarding a dentist's membership status, specialty and office location.

PLAN INFORMATION

Benefit Summary Charts

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

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

Benefit Summary Chart

| Category of Service | Paid by Delta Dental | Paid By Enrollee |
|--|-------------------------|---------------------|
| Diagnostic | 80%* | 20% |
| Periodic exams (twice per calendar year) | | |
| Bitewing x-rays | | |
| Full-mouth x-ray | | |
| Preventive | 80%* | 20% |
| Prophylaxis (cleaning) (twice per calendar year) | | |
| Fluoride treatments (twice per calendar year to age 19) | | |
| Sealants (to age 14) | | |
| Space maintainers (to age 14) | | |
| Basic Restorative | 80%* | 20% |
| Fillings (amalgam “silver” and composite “white” non-molar) | | |
| Major Restorative | 80%* | 20% |
| Single crowns, inlays, onlays | | |
| Oral Surgery | 80%* | 20% |
| Extraction and other oral surgery procedures, incl. pre- and post-operative care | | |
| Endodontics | 80%* | 20% |
| Root canal, pulpal therapy | | |
| Surgical Periodontics | 80%* | 20% |
| Surgical treatment of the gums and supporting structures of the teeth, includes procedure code 04381 for Arestin treatment | | |
| Non-Surgical Periodontics | 80%* | 20% |
| Non-surgical treatment of the gums and supporting structures of the teeth | | |
| Prosthodontics | 80%* | 20% |
| Procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures; implant surgical placement (one implant per calendar year) and removal; implant supported prosthetics, including repair and recementation | | |
| General Anesthesia | 80%* | 20% |
| Covered when used in conjunction with covered oral surgical procedures | | |
| Emergency Services | | |
| Palliative Treatment | **%* | **% |

| | Deductibles | Maximums |
|----------------------------|--------------------|-----------------|
| Individual (Contract year) | \$100.00 | \$5,000.00*** |
| Family (Contract year) | \$300.00 | \$ n/a |

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

**** At least \$50.00 or the cost of the Treatment, whichever is less.**

*****Maximum does not apply to dependent children under age 19.**

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

Benefit Summary Chart

| Category of Service | Paid by Delta Dental | Paid By Enrollee |
|--|---------------------------------|-----------------------------|
| Diagnostic | 80%* | 20% |
| Periodic exams (twice per calendar year) | | |
| Bitewing x-rays | | |
| Full-mouth x-ray | | |
| Preventive | 80%* | 20% |
| Prophylaxis (cleaning) (twice per calendar year) | | |
| Fluoride treatments (twice per calendar year to age 19) | | |
| Sealants (to age 14) | | |
| Space maintainers (to age 14) | | |
| Basic Restorative | 80%* | 20% |
| Fillings (amalgam “silver” and composite “white” non-molar) | | |
| Major Restorative | 80%* | 20% |
| Single crowns, inlays, onlays | | |
| Oral Surgery | 80%* | 20% |
| Extraction and other oral surgery procedures, incl. pre- and post-operative care | | |
| Endodontics | 80%* | 20% |
| Root canal, pulpal therapy | | |
| Surgical Periodontics | 80%* | 20% |
| Surgical treatment of the gums and supporting structures of the teeth, includes procedure code 04381 for Arestin treatment | | |
| Non-Surgical Periodontics | 80%* | 20% |
| Non-surgical treatment of the gums and supporting structures of the teeth | | |
| Prosthodontics | 80%* | 20% |
| Procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures; implant surgical placement (one implant per calendar year) and removal; implant supported prosthetics, including repair and recementation | | |
| General Anesthesia | 80%* | 20% |
| Covered when used in conjunction with covered oral surgical procedures | | |
| Emergency Services | **%* | **% |
| Palliative Treatment | | |

| | Deductibles | Maximums |
|----------------------------|--------------------|-----------------|
| Individual (Contract year) | \$100.00 | \$5,000.00*** |
| Family (Contract year) | \$300.00 | \$ n/a |

* For Delta Dental Premier dentists and Non-Participating dentists, percentages are based on the Premier Allowed Amount, which is the lesser of the dentist’s submitted fee or the Premier Maximum Plan Allowance. For Non-Participating dentists, the enrollee’s responsibility is the copayment plus the difference between the non-participating dentist’s submitted amount and the Premier Maximum Plan Allowance.

** At least \$50.00 or the cost of the Treatment, whichever is less.

***Maximum does not apply to dependent children under age 19.

Copayments

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

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

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

Deductible

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

Maximum Benefit

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

Limitations and Exclusions

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

HOW CLAIMS ARE PAID

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

Payment for Services — Delta Dental PPO Dentist

Payment for covered services performed for you by a PPO dentist is based on the PPO maximum plan allowance. PPO dentists have agreed to accept a PPO maximum plan allowance as the full charge for covered services.

Delta Dental calculates its share of the maximum plan allowance, or the dentist's submitted fee, whichever is less, ("Delta Dental Payment") using the applicable percentage from the Benefit Summary Chart and sends it directly to the PPO dentist who has submitted the claim. Delta Dental advises you of any charges not payable by Delta Dental for which you are responsible ("Patient Payment"). These charges are generally your share of the maximum plan allowance or submitted fee (copayment), the deductible, charges where the maximum benefit has been exceeded, and/or charges for non-covered services.

Payment for Services — Delta Dental Premier Dentist

A Delta Dental Premier dentist is a participating dentist, but is not a Delta Dental PPO dentist. Premier dentists have not agreed to accept a PPO maximum plan allowance as full payment for services, but instead have agreed to accept a Premier maximum plan allowance. Payment for covered services performed for you by a Premier dentist is calculated based on the Premier allowed amount, which is the lesser of the dentist's submitted fee or the Premier maximum plan allowance.

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

Payment for Services — Non-Participating Dentist

Payment for services performed for you by a non-participating dentist is also calculated by Delta Dental based on the Premier allowed amount, which is the lesser of the dentist's submitted fee or the Premier maximum plan allowance. The portion of the Premier allowed amount payable by Delta Dental ("Delta Dental's Payment") is limited to the applicable percentage shown in the Benefit Summary Chart.

When dental services are received from a non-participating dentist, Delta Dental's Payment is sent directly to the primary enrollee. You are responsible for payment of the non-participating dentist's total fee. Non-participating dentists will bill you for their normal charges, which may be higher than the Premier allowed amount for the service. You may be required to pay the dentist yourself and then submit a claim to Delta Dental for reimbursement. Since the Delta Dental Payment for services you receive may be less than the non-participating dentist's actual charges, your out-of-pocket cost may be significantly higher.

How to Submit a Claim

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

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

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|---|
| <p style="text-align: center;">Delta Dental P.O. Box 2105 Mechanicsburg, PA 17055-6999</p> |
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Payment Guidelines

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

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

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

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

Optional Treatment and Non-Covered Services

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

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

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

Pre-Treatment Estimates

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

Other Dental Insurance – Non-Duplication of Benefits

If you or a qualified dependent are covered under another dental plan (for example, if you are covered as a dependent under your spouse's dental plan), that plan's dental benefits will be coordinated with the benefits provided under the MEBA Plan.

Coverage under a "no fault" or medical payments provision of an automobile insurance policy is also subject to coordination with your MEBA Plan benefits. The Plan's complete coordination of benefits rules are contained in Article XVII of the Medical and Benefits Plan Regulations, and are summarized briefly below.

Under coordination of benefits, if you or any of your qualified dependents have coverage under another dental plan, the MEBA Plan and the other plan(s) will coordinate with each other to prevent duplicate benefit payments. Coordination of benefits only applies when someone has two or more dental plan coverages. If the MEBA Plan is the only plan that covers an individual filing a claim, then coordination of benefits does not apply.

First, the "primary plan" pays all the benefits it would normally pay without regard to any other coverage you or a dependent might have. Then, the "secondary plan" pays all the benefits it would normally pay minus the benefits paid by the primary plan.

Primary and secondary plans are generally determined as follows:

- The plan that covers someone as an employee (rather than as a dependent) is the primary plan.
- The plan that covers someone as a dependent spouse of an employee is the secondary plan.
- For dependent children who are covered under plans of both parents, the "birthday rule" is used. Under the birthday rule, the plan of the parent whose birthday is earlier in the year is the primary plan and the plan of the parent whose birthday is later in the year is the secondary plan. (If both parents have the same birthday, then the plan that has covered the child longest is the primary plan.)

When children are covered under plans of divorced or separated parents or where the parents are not living together, or whether or not they have ever been married, the primary plan is generally determined as follows:

- If a court decree states one of the parents is responsible for the dependent child's health care coverage, that plan is primary. If the parent with responsibility has no health care coverage, but the parent's spouse does have health care coverage, that parent's spouse's plan is the primary plan.
- If a court decree states that both parents are responsible for the dependent child's health care coverage, then refer to the "birthday rule" for determination.

- If a court decree states that both parents have joint custody but does not specify which parent is responsible, then refer to the “birthday rule” for determination.
- If there is no court decree which addresses responsibility for dependent child’s health care coverage, the order of determination will be as follows:
 - i. The plan covering the custodial parent;
 - ii. The plan covering the custodial parent’s spouse;
 - iii. The plan covering the non-custodial parent; and then
 - iv. The plan covering the non-custodial parent’s spouse.

If the above rules do not resolve which plan is primary, then the plan that is covering the individual as an active employee is primary and the plan covering the individual as a pensioner is secondary.

Remember, the above is only a summary of the coordination of benefits rules. See the Plan Regulations for complete details.

Who Is Eligible ***Employee Coverage***

As a new entrant into the Plan, you become covered by the Plan on the date you complete 30 days of Covered Employment in any six consecutive calendar months. Thereafter, in order to maintain eligibility, you must complete 60 days on the payroll in Covered Employment within any period of six consecutive calendar months, unless you were totally disabled on February 1, 2006, in which case a special rule applies. Absence of work due to any health factor (e.g., sick leave or hospitalization) is treated as being in covered employment for purposes of counting the days for eligibility. Days of attendance at the MEBA Engineering School count for purposes of determining your eligibility for Plan benefits (unless you are otherwise entitled to such credit as work in covered employment or unless you are receiving vacation benefits paid by the MEBA Vacation Plan).

Your Plan coverage continues for six months following the last day of Covered Employment that was used to earn your eligibility. If you become totally disabled, your coverage continues for 18 months after the last day of Covered Employment that was used to earn your eligibility, but only so long as you are considered totally disabled by the same disability.

If you are employed by District No. 1-PCD, MEBA (the “Union”), the Engineering School, the Plan Office, or another employer that covers non-collectively bargained employees, your coverage begins after you complete one month of continuous employment and ends on the last day of the month in which your employment terminates.

In all cases, your coverage ends immediately upon entering military service unless you elect to continue coverage under the Uniformed Services Employment and Re-employment Rights Act (“USERRA”).

Dependent Coverage

While you are covered by the Plan your qualified dependents are also covered for medical and dental benefits. Your qualified dependents are:

- Your spouse (coverage for your spouse ends on the date of divorce, legal separation or when you and your spouse enter into a written agreement to live separately);
- Your unmarried children (including adopted children) under age 19 (stepchildren are covered if they are members of your household and dependent on you for support);
- Children for whom you are obligated to provide medical coverage under a Qualified Medical Child Support Order;
- Your married or unmarried children to age 26;
- Your dependent parents if you do not have a spouse or children who qualify as dependents, your parents are principally dependent on you for support, and they are claimed as dependents on your federal income tax return; and

- Your grandchildren, but only if a court has awarded you legal custody of them, you have tried to adopt them but have been unable to do so, both parents of the grandchildren are deceased, incarcerated, totally disabled or unable to care for them, and you claim the grandchildren as dependents on your federal income tax return. Coverage for grandchildren under this Plan is subject to the maximum pre-existing condition exclusion permitted by law for the first 12 months of coverage.

The age limits for dependent children do not apply to an unmarried child who is incapable of self-sustaining employment by reason of mental or physical disability, provided the child became so incapable before the age limit was reached.

Coverage for your qualified dependents ends when your coverage ends, or when they cease to be qualified dependents as defined above. If you die while covered, coverage for your qualified dependents continues at no cost for five calendar months after the month of your death.

Remember, the above is only a summary of the eligibility rules. See the Plan Regulations for complete details.

Extension of Benefits

In the event that your coverage is terminated, Delta Dental will extend benefits for at least 90 days beyond the date on which your coverage terminates or until the services are complete if the treatment: (1) begins before the date coverage terminates; and (2) requires two or more visits on separate days to a dentist's office.

COMPLAINTS, GRIEVANCES AND APPEALS

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

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

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

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

Appeals

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

Appeals on claims denied must be submitted in writing. For an explanation as to your rights of appeal, please refer to the Claims Denial Review Procedure that is furnished automatically without charge as a separate document that accompanies this booklet.

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

| |
|--|
| <p style="text-align: center;">Delta Dental One Delta Drive Mechanicsburg, PA 17055</p> |
|--|

GENERAL PROGRAM INFORMATION**Proof of Claim**

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

Physical Access

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

Access for the Hearing Impaired

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

Privacy

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

Web Site Security

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

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

ENROLLEE RIGHTS AND RESPONSIBILITIES

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

The Right to Choose

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

The Right to Quality Assurance

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

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

The Right to Affordability

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

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

The Right to Full Disclosure

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

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

The Right to Fair Review and Appeal

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

The Responsibility to Protect These Rights

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

- The responsibility to participate in your own dental health — practicing personal dental hygiene and receiving regular professional care. You should avoid substances and behaviors that could jeopardize your oral health, and should cooperate with your dentist on his or her recommended treatment plans.
- The responsibility to become familiar with your coverage. This includes meeting any financial obligation incurred as a result of treatment (including the appropriate copayments or deductibles required by the program). It means cooperation with Delta Dental policies designed to protect against health care fraud schemes by fellow enrollees or dentists. It also means taking advantage of the information available on dental health and your dental program so that you can become a more informed consumer.

LIMITATIONS AND EXCLUSIONS**Excluded Benefits**

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

The plan does not provide benefits for:

1. Treatment or materials that are benefits to an enrollee under Medicare or Medicaid unless this exclusion is prohibited by law.
2. Treatment or materials to correct congenital or developmental malformations (including treatment of enamel hypoplasia) except for newborn children eligible at birth, so long as such eligible children continue to be enrolled. When services are not excluded under this provision, congenital defects or anomalies specifically includes individuals born with cleft lip or cleft palate, and other limitations and exclusions of this section shall specifically apply.
3. Treatment that increases the vertical dimension of an occlusion, replaces tooth structure lost by attrition or erosion, or otherwise unless it is part of a treatment dentally necessary due to accident or injury.
4. Treatment or materials primarily for cosmetic purposes including but not limited to treatment of fluorosis (a type of discoloration of the teeth) and porcelain or other veneers not for restorative purposes, except as part of a treatment dentally necessary due to accident or injury. If services are not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent or near the affected teeth are excluded.
5. Treatment or materials for which the enrollee would have no legal obligation to pay.

6. Services provided or materials furnished prior to the effective eligibility date of an enrollee under this plan, unless the treatment was a year in duration and completed after the enrollee became eligible if no other limitations shall apply.
7. Periodontal splinting, equilibration, gnathological recordings and associated treatment and extra-oral grafts.
8. Preventive plaque control programs, including oral hygiene instruction programs.
9. Myofunctional therapy, unless covered by the exception in Item 2, above.
10. Temporomandibular joint dysfunction, unless covered by the exception in Item 2, above.
11. Prescription drugs including topically applied medication for treatment of periodontal disease, pre-medication, analgesias, separate charges for local anesthetics, general anesthesia except as a covered benefit in conjunction with a covered oral surgery procedure.
12. Experimental procedures that have not been accepted by the American Dental Association.
13. Services provided or material furnished after the termination date of coverage for which premium has been paid, as applicable to individual enrollees, except this shall not apply to services commenced while the plan was in effect or the enrollee was eligible.
14. Charges for hospitalization or any other surgical treatment facility, including hospital visits.
15. Dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks, or relaxation techniques such as music.
16. Replacement of existing restorations for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.
17. Payment of any claim, bill or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral.
18. Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered benefit.

Limitations

Benefits to enrollees are limited as follows:

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

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

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

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

Implants provided under any Delta Dental plan will be replaced only after five years have passed. Replacement of an implant supported prosthesis not provided under a Delta Dental program will be covered if it is unsatisfactory and cannot be made satisfactory. Implant removal is limited to once for each tooth during the Enrollee's lifetime.

Limitation on Oral Surgery Benefits. Delta Dental's obligation for these oral surgery services shall be limited to the difference between benefits paid under such other contracts up to the allowed amount for the procedure less the applicable deductible and enrollee copayment. When there is no medical or hospital coverage, Delta Dental's obligation for oral surgery services shall be limited to the allowed amount for those services provided under the contract less the applicable deductible and enrollee copayment.

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

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

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

DEFINITION OF TERMS

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

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

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

Calendar Year: The time period beginning on January 1st and ending on December 31st.

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

Company: The organization or group contracting to obtain benefits.

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

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

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

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

Delta Dental PPO plus Premier: A dental care program under which all fees paid by Delta Dental for covered services provided by a PPO dentist shall be based on the PPO allowed amount, subject to any applicable copayments, deductibles and maximums. All fees paid by Delta Dental for services provided by a Premier dentist who is not a PPO dentist or by a Non-Participating dentist shall be based on the Premier allowed amount.

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

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

Delta Dental PPO ("PPO") Maximum Plan Allowance: The maximum amount payable by Delta Dental for a covered dental service in a PPO program. Delta Dental establishes the maximum plan allowance for each procedure through a review of proprietary filed fee data and actual submitted claims. Maximum plan allowances are typically set annually to reflect charges based on actual submitted claims from dentists in the same geographical area with similar professional standing. The enrollee's financial obligation beyond the maximum plan allowance is determined by any maximums, deductible and co-payment amounts.

Delta Dental Premier ("Premier") Maximum Plan Allowance: The maximum amount payable by Delta Dental for a covered dental service in a Premier program. Delta Dental establishes the maximum plan allowance for each procedure through a review of proprietary filed fee data and actual

submitted claims. Maximum plan allowances are typically set annually to reflect charges based on actual submitted claims from dentists in the same geographical area with similar professional standing. The enrollee's financial obligation beyond the maximum plan allowance is determined by any maximums, deductible and copayment amounts.

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

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

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

Enrollee: Collectively, the primary enrollee and all enrolled dependents.

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

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

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

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

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

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

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

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

PPO Allowed Amount: For covered services, the PPO allowed amount under this plan is the lesser of the dentist's submitted fee or the PPO maximum plan allowance. For non-covered services, the PPO allowed amount is zero.

Premier Allowed Amount: For covered services, the Premier allowed amount under this plan is the lesser of the dentist's submitted fee or the Premier maximum plan allowance. For non-covered services, the Premier allowed amount is zero.

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

Primary Enrollee: An Employee who is enrolled in this dental plan.

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

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

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

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

DELTA DENTAL OF PENNSYLVANIA'S INTERNAL GRIEVANCE PROCEDURE

(1) *Denial of payment based upon lack of coverage of benefit under the Contract or Enrollee's eligibility status i.e. coverage decisions made pursuant to Title 15, Subtitle 10D of the Maryland Insurance Article, that are **not** considered Adverse Decisions under Title 15, Subtitle 10A of the Maryland Insurance Article.*

If a post-service claim¹ is denied in whole or in part, Delta Dental shall notify the Enrollee, the Enrollee's Representative, and the attending dentist of the denial in writing within thirty (30) days after the claim is filed, unless special circumstances require an extension of time, not exceeding, fifteen (15) days for processing. If there is an extension, the Enrollee, the Enrollee's Representative, and the attending dentist shall be notified of the extension and the reason for the extension within the original thirty (30) day period. If an extension is necessary because either the Enrollee, the Enrollee's Representative, or the attending dentist did not submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information. The Enrollee, the Enrollee's Representative, or the attending dentist shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specific information. The extension period (fifteen (15) days) – within which a decision must be made by Delta Dental – will begin to run from the date on which the Enrollee's response is received by Delta Dental (without regard to whether all of the requested information is provided) or, if earlier, the due date established by Delta Dental for furnishing the requested information (at least forty-five (45) days).

The notice of denial shall explain the specific reason or reasons why the claim was denied in whole or in part, including a specific reference to the pertinent Contract provisions on which the denial is based, a description of any additional material or information necessary for the Enrollee to perfect the claim and an explanation as to why such information is necessary. The notice of denial shall also contain an explanation of Delta Dental's claim review and appeal process and the time limits applicable to such process, including a statement of the Enrollee's right to bring a civil action under ERISA upon completion of Delta Dental's second level of review. The notice shall refer to any internal rule, guideline, and protocol that were relied upon (and that a copy will be provided free of charge upon request). The notice shall also include the following statement:

ATTN. FULLY INSURED MARYLAND ENROLLEES: THERE IS HELP AVAILABLE TO YOU IF YOU WISH TO DISPUTE THE DECISION OF THE PLAN ABOUT PAYMENT FOR HEALTH CARE SERVICES. You, your Representative, or your Health Care Provider may contact the Health Advocacy Unit of Maryland's Consumer Protection Division at: Office of the Attorney General, 200 Saint Paul Place, 16th Floor, Baltimore, Maryland 21202. The phone number is 877-261-8807 (toll free) or 410-528-1840 and TTY is 1-800-576-6372. The fax number is 410-576-6571 and the email address is consumer@oag.state.md.us. The Health Advocacy Unit can help you, your Representative or your Health Care Provider prepare a Grievance to file under the carrier's internal Grievance procedure. That unit can also attempt to mediate a resolution to your dispute and file a Complaint with the Commissioner. The Health Advocacy Unit is not available to represent or accompany you during any proceeding of the internal Grievance process. Additionally, you, your Representative, or your Health Care Provider may file a Complaint with the Maryland Insurance Administration at: Attn: Consumer Complaint Investigation, Life and Health/Appeals and Grievance, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202, Phone: 1-800-492-6116 or 410-468-2000, TTY: 1-800-735-2258, Fax: 410-468-2270 or 410-468-2260. The Complaint may be filed without having to first file a Grievance with Delta Dental, if: (1) Delta Dental has waived the requirement that its internal Grievance process be exhausted; (2) Delta Dental failed to comply with any of the requirements of the internal Grievance process; or (3) You, your Representative or your Health Care Provider can show a compelling reason to file a Complaint, including that a delay in receiving the Health Care Service could result in loss of life, serious impairment to a bodily function, or serious dysfunction of a bodily organ or part, or the Enrollee remaining seriously mentally ill with symptoms that cause the Enrollee to be in danger to self or others. **INFORMATION DESCRIBED IN THIS NOTICE MAY ALSO BE FOUND IN THE GROUP CONTRACT.**

¹Delta Dental does not condition receipt of a benefit, in whole or in part, upon approval of the benefit in advance of obtaining dental care. Additionally, Delta Dental does not conduct concurrent review relating to continued or extended health care services, or additional services for an insured undergoing a course of continued treatment.

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

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

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

If in the opinion of the Enrollee, the Enrollee's Representative, or attending dentist, the matter warrants further consideration, the Enrollee, the Enrollee's Representative, or the attending dentist should advise Delta Dental in writing as soon as possible. The matter shall then be immediately referred to Delta Dental's Dental Affairs Committee. This stage can include a clinical examination, if not done previously, and a hearing before Delta Dental's Dental Affairs Committee if requested by the Enrollee, the Enrollee's Representative, or the attending dentist. The Dental Affairs Committee will render a decision within thirty (30) days of the request for further consideration, or within sixty (60) working days of the initial request for review described above, whichever is sooner. The notice of decision will state the specific factual bases for the decision. It will also include: the Maryland Insurance Commissioner's address, telephone number, and facsimile number; a statement that the Enrollee, the Enrollee's Representative, or his or her dentist, has a right to file a Complaint with the Maryland Insurance Commissioner within four (4) months after receipt of Delta Dental's appeal decision; a statement that the Health Advocacy Unit is available to assist the Enrollee, the Enrollee's Representative, or the attending dentist in filing a Complaint with the Commissioner; and the address, telephone number, facsimile number and email address of the Health Advocacy Unit. The decision of the Dental Affairs Committee shall be final insofar as Delta Dental is concerned. Recourse thereafter would be to the Maryland Insurance Commissioner, or to the courts with an ERISA or other civil action.

(2) *Denial of a covered benefit where the service is not dentally necessary, appropriate or efficient, i.e. claim benefit determinations that are considered Adverse Decisions - under Title 15, Subtitle 10A of the Maryland Insurance Article.*

I. Definitions

- A. Adverse Decision shall mean a utilization review determination by a Private Review Agent, a carrier, or a Health Care Provider acting on behalf of a carrier that: (1) a proposed or delivered Health Care Service covered under the Enrollee's contract is or was not medically necessary, appropriate, or efficient; and (2) may result in non-coverage of Health Care Service. An Adverse Decision does not include a decision concerning an Enrollee's status.
- B. Complaint shall mean a protest filed with the Commissioner involving an Adverse Decision or Grievance Decision concerning an Enrollee.
- C. Enrollee shall mean a person entitled to health care benefits under a policy, plan, or certificate issued or delivered in Maryland by Delta Dental. Unless preempted by federal law, Enrollee includes a Medicare recipient. Enrollee does not include a Medicaid recipient.
- D. Enrollee's Representative shall mean a person who has been authorized by the Enrollee to file a Grievance on behalf of the Enrollee.
- E. Filing Date shall mean the earlier of five (5) days after the date of mailing or the date of receipt.
- F. Grievance shall mean a protest filed by an Enrollee, an Enrollee's Representative, or a Health Care Provider on behalf of an Enrollee with Delta Dental through Delta Dental's internal Grievance process regarding an Adverse Decision concerning the Enrollee.
- G. Grievance Decision shall mean a final determination by Delta Dental that arises from a Grievance filed with Delta Dental under its internal Grievance process regarding an Adverse Decision concerning an Enrollee.
- H. Health Advocacy Unit shall mean the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of Attorney General established under Commercial Law Article, Title 13, Subtitle 4A, Annotated Code of Maryland.
- I. Health Care Provider shall mean: (1) an individual who is licensed under the Health Occupations Article to provide Health Care Services in the ordinary course of business or practice of a profession and is a treating provider of the Enrollee; or (2) a hospital, as defined in section 19301 of the Health-General Article.
- J. Health Care Service shall mean a health or medical care procedure or service rendered by a Health Care Provider including: (1) testing, diagnosis, or treatment of a human disease or dysfunction; (2) dispensing drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction; and (3) any other care, service, or treatment of disease or injury, the correction of defects, or the maintenance of the physical and mental well-being of an individual.
- K. Private Review Agent shall mean: (1) a non-hospital affiliated person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of a Maryland business entity or a third party that provides or administers hospital benefits to citizens of Maryland including a health maintenance organization, a health insurer, nonprofit health service plan, health insurance service organization, or preferred provider organization authorized to offer health insurance policies or contracts in Maryland; or (2) any person or entity including a hospital-affiliated person performing utilization review for the purpose of making claims or payment decisions on behalf of the employer's or labor union's health insurance plan under an employee assistance program for employees other than the employees employed by the hospital; or employed by a business wholly owned by the hospital.

II. Standard Claims Procedure

- A. Processing of Claims: Delta Dental shall process all claims as expediently as possible. Within 30 days after receipt of a claim, Delta Dental shall either:

1. Pay the entire claim or any undisputed portion of the claim;
2. Send a notice of receipt and status of the claim in accordance with sections II(B) and II(C) below that states that Delta Dental denies all or part of the claim and the reason for the denial; or
3. If within three (3) calendar days after receipt of the initial request for Health Care Services, Delta Dental does not have sufficient information to make a determination, Delta Dental shall inform the attending dentist of the information necessary to make the determination.
4. Send a notice of receipt and status of the claim that states that Delta Dental will require an additional fifteen (15) days² to process the claim due to the failure of the Enrollee to submit the information necessary to decide the claim. The notice will state either that:
 - a. The legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or
 - b. That the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim.

The Enrollee, the Enrollee's Representative, or the attending dentist shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specific information.

B. Rendering of an Adverse Decision: When Delta Dental renders an Adverse Decision³ on all or part of a post-service claim⁴, Delta Dental shall:

1. Provide oral communication of the decision to the Enrollee, the Enrollee's Representative, or the attending dentist;
2. Document the Adverse Decision in writing after Delta Dental has provided oral communication of the decision to the Enrollee, the Enrollee's Representative, or the attending dentist.

²The extension period (fifteen (15) days) – within which a decision must be made by Delta Dental – will begin to run from the date on which the Enrollee's response is received by the plan (without regard to whether all of the requested information is provided) or, if earlier, the due date established by the plan for furnishing the requested information (at least forty-five (45) days).

³All Adverse Decisions i.e., decisions which are based upon whether a service was medically necessary, appropriate, or efficient, shall be made by a licensed dentist, or a panel of other appropriate Health Care Service reviewers with at least one licensed dentist on the panel.

⁴Delta Dental does not condition receipt of a benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care. Additionally, Delta Dental does not conduct concurrent review relating to continued or extended Health Care Services, or additional services for an insured undergoing a course of continued treatment.

C. Notice of Adverse Decision: Within 5 working days after the Adverse Decision has been made, Delta Dental shall send a written notice to the Enrollee, the Enrollee's Representative, and the attending dentist that:

1. States in detail in clear, understandable language the specific factual bases for the carrier's decision;
2. References the specific criteria and standards, including interpretive guidelines on which the decision was based;
3. States the name, business address, and business telephone number of the designated Delta Dental employee or representative who is responsible for Delta Dental's internal Grievance process as follows:

[Alice Strobel
Manager, Professional Services
Delta Dental
11155 International Drive
Rancho Cordova, CA 95670
Phone: 916-861-2612
Fax: 916-631-6374
Email: astrobel@delta.org]

4. Gives written details of Delta Dental's internal Grievance process and procedures as follows:

If you, your Representative, or your attending dentist want the Adverse Decision reviewed, you, your Representative, or your attending dentist must contact Delta Dental, either in writing or by calling Delta Dental's toll-free number, 1-800-932-0783, **within one hundred eighty (180) days of the date on this notice**. You, your Representative, or your attending dentist should state why the claim should not have been denied. Also, any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. You, your Representative, or your attending dentist are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered initially.

The review shall be conducted for Delta Dental by a licensed dentist who is neither the licensed dentist who made the claim denial that is the subject of the review, nor the subordinate of such individual. The review shall be conducted by a licensed dentist, or a panel of appropriate Health Care Service reviewers with at least one dentist on the panel who is a licensed dentist. Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such dental consultant. The identity of such dental consultant is available upon request whether or not the advice was relied upon. In making the review, Delta Dental will not afford deference to the initial Adverse Decision.

If after review, Delta Dental continues to deny the claim, Delta Dental shall notify you, your Representative, or your attending dentist in writing of the Grievance Decision within forty-five (45) days of the date the request is received. Delta Dental shall send you, your Representative, or your attending dentist a notice, similar to this notice. If in the opinion of you, your Representative, or your attending dentist, the matter warrants *further* consideration, you may file an action in the courts pursuant to section 502(a) of ERISA. If you are a fully insured Enrollee, you, your Representative, or your attending dentist also have the option to file a Complaint with the Maryland Insurance Administration within four (4) months after receipt of Delta Dental's Grievance Decision. A Complaint may be filed

without first filing a Grievance if: (1) Delta Dental has waived the requirement that its internal Grievance process be exhausted; (2) Delta Dental failed to comply with any of the requirements of the internal Grievance process; or (3) You, your Representative, or your attending dentist can demonstrate a compelling reason to do so as determined by the Maryland Insurance Administration.

5. Includes the following information:
 - a. That, if the Enrollee is fully insured, the Enrollee, the Enrollee's Representative, or attending dentist has a right to file a Complaint with the Commissioner within four (4) months after receipt of Delta Dental's Grievance Decision;
 - b. The following disclosure in at least 12-point typeface, with the first sentence in bold capital typeface:

ATTN. FULLY INSURED MARYLAND ENROLLEES: THERE IS HELP AVAILABLE TO YOU IF YOU WISH TO DISPUTE THE DECISION OF THE PLAN ABOUT PAYMENT FOR HEALTH CARE SERVICES. You, your Representative, or your Health Care Provider may contact the Health Advocacy Unit of Maryland's Consumer Protection Division at: Office of the Attorney General, 200 St. Paul Place, 16th Floor, Baltimore, Maryland 21202. The phone number is 877-261-8807 (toll-free) or 410-528-1840 and TTY is 1-800-576-6372. The fax number is 410-576-6571 and the email address is consumer@oag.state.md.us. The Health Advocacy Unit can help you, your Representative, or your Health Care Provider prepare a Grievance to file under Delta Dental's internal Grievance procedure. That unit can also attempt to mediate a resolution to your dispute and file a Complaint with the Commissioner. The Health Advocacy Unit is not available to represent or accompany you during any proceeding of the internal Grievance process. Additionally, you, your Representative, or your Health Care Provider may file a Complaint with the Maryland Insurance Administration at: Attn: Consumer Complaint Investigation, Life and Health/Appeals and Grievance, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202, Phone: 1-800-492-6116 or 410-468-2000, TTY: 1-800-735-2258, Fax: 410-468-2270 or 410-468-2260. The Complaint may be filed without having to first file a Grievance with Delta Dental, if: **(1) Delta Dental has waived the requirement that its internal Grievance process be exhausted; (2) Delta Dental failed to comply with any of the requirements of the internal Grievance process; or (3) You, your Representative, or your Health Care Provider can show a compelling reason to file a Complaint, including that a delay in receiving the Health Care Service could result in loss of life, serious impairment to a bodily function, or serious dysfunction of a bodily organ or part, or the Enrollee remaining seriously mentally ill with symptoms that cause the Enrollee to be in danger to self or others. INFORMATION DESCRIBED IN THIS NOTICE MAY ALSO BE FOUND IN YOUR GROUP CONTRACT.**

III. Internal Grievance Procedure

- A. Informal Inquiry Option: If a claim is denied in whole or in part, an Enrollee, an Enrollee's Representative, or his or her attending dentist may make an informal inquiry regarding general program, eligibility questions and Adverse Decisions by contacting Delta Dental via its toll-free number at 1-800-932-0783. Every caller has access to a supervisor if dissatisfied with the response.
- B. Non-emergency Appeals of Adverse Decisions: In lieu of making an informal inquiry, an Enrollee, an Enrollee's Representative, or his or her attending dentist may choose to appeal the Adverse Decision. The Enrollee, Enrollee's Representative or Health Care Provider may do so within one hundred eighty (180) days, either by writing to Delta Dental or by calling Delta Dental at its toll-free number. Written acknowledgement of the filing of the appeal to the appealing party will be provided to the Enrollee, the Enrollee's Representative, or the attending dentist within five (5) days of the filing of the appeal. The letter or oral request for appeal should state why the claim should not have been denied. Also any

other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. The Enrollee, the Enrollee's Representative, or the attending dentist are entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim.

- C. Notification of Information Necessary to Conduct the Internal Grievance Process: If Delta Dental requires information necessary to conduct the internal Grievance process, Delta Dental shall notify the Enrollee, the Enrollee's Representative, or the attending dentist, in writing within five (5) working days of receipt of the appeal, to identify and request the necessary information. In the event that only a portion of such necessary information is received, Delta Dental shall request the missing information, in writing, within five (5) working days of receipt of the partial information. Delta Dental will assist the Enrollee, the Enrollee's Representative, or the Health Care Provider in gathering the necessary information without further delay.
- D. The Review: The review shall be conducted for Delta Dental by a dental consultant who is neither the dental consultant who made the claim denial that is the subject of the review, nor the subordinate of such individual. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination. The review shall be conducted by a licensed dentist, or a panel of appropriate Health Care Service reviewers with at least one dentist on the panel who is a licensed dentist. Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta Dental dental consultant whose advice was obtained in connection with the denial of the claim whether or not the advice was relied upon in making the benefit determination is also available on request. In making the review, Delta Dental will not afford deference to the initial Adverse Decision. A clinical examination at Delta Dental's cost may be implemented, along with discussion among dentist consultants. At this point, the Enrollee may also request a hearing.
- E. Grievance Decision: Delta Dental shall make a Grievance Decision within forty-five (45) days of the date the Grievance is filed. However, Delta Dental may extend this 45-day period with the written consent of the Enrollee, the Enrollee's Representative, or the attending dentist who filed the Grievance on behalf of the Enrollee, for a period of no longer than thirty (30) working days. Delta Dental shall document the Grievance Decision in writing after Delta Dental has provided oral communication of the decision to the Enrollee, the Enrollee's Representative, or the attending dentist. Within five (5) days after the Grievance Decision has been made, Delta Dental shall send a written notice to the Enrollee, the Enrollee's Representative, or the attending dentist in accordance with Section IV below. The Grievance Decision shall be final insofar as Delta Dental is concerned. Recourse thereafter would be to the courts with an ERISA or other civil action, or to the Maryland Insurance Administration.
- F. Complaints: An Enrollee, an Enrollee's Representative, or the attending dentist has a right to file a Complaint with the Commissioner within four (4) months after receipt of Delta Dental's Grievance Decision. When filing a Complaint with the Commissioner, the Enrollee or the Enrollee's Representative will be required to authorize the release of any medical records of the Enrollee that may be required to be reviewed for the purpose of reaching a decision on the Complaint.

IV. Distribution of Information to Enrollees/Enrollees' Representatives/Attending Dentists Upon Entry of Grievance Decision. The paragraphs below outline the contents of the Notification of Grievance Decision.

- A. Content and Notification of Grievance Decision. If after the claim is reviewed, Delta Dental continues to deny the claim, Delta Dental shall send the Enrollee, the Enrollee's Representative, or the attending dentist a notice, which contains:
 - 1. A clear statement in understandable language containing the specific factual basis for Delta Dental's decision;

2. A clear statement that the notice constitutes Delta Dental's final Grievance Decision;
3. Reference to the specific criteria and standards, including interpretive guidelines, on which the decision was based (without using only generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary");
4. The name, business address, and business telephone number of the designated employee or Delta Dental representative who has responsibility for Delta Dental's internal Grievance process as follows:

[Alice Strobel
Manager, Professional Services
Delta Dental
11155 International Drive
Rancho Cordova, CA 95670
Phone: 916-861-2612
Fax: 916-631-6374
Email: astrobel@delta.org]

5. A statement that a fully insured Enrollee, Enrollee's Representative, or Health Care Provider who has filed the Grievance on behalf of a fully insured Enrollee, has a right to file a Complaint with the Commissioner within four (4) months after receipt of Delta Dental's Grievance Decision;
6. The Commissioner's address, telephone number and facsimile number as follows:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health/Appeals and Grievance
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: 1-800-492-6116 or 410-468-2000
TTY: 1-800-735-2258
Fax: 410-468-2270 or 410-468-2260

7. A statement that the Health Advocacy Unit is available to assist the Enrollee or the Enrollee's representative in both mediating and filing a Grievance under Delta Dental's internal Grievance process and filing a Complaint with the Commissioner.
8. The address, telephone number, facsimile number, and email address of the Health Advocacy Unit of Maryland's Consumer Protection Division as follows:

Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840
Toll Free: 877-261-8807
TTY: 1-800-576-6372
Fax: 410-576-6571
Email: consumer@oag.state.md.us