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## **Your Member Handbook**

This Member Handbook is designed to help you get the most from your dental plan. It highlights the key things you need to know as an enrollee. The handbook is intended to answer questions you may have about your covered benefits.

Also included in this handbook is your Benefit Summary Guide (BSG). The BSG is your actual explanation of covered benefits as an enrollee. While this handbook is a general guide to using your benefits, the BSG is always the ultimate source of information about covered benefits, exclusions, limitations, membership provisions and is a part of your group's contract. Please review your BSG.

## **How to Contact Us**

### **BY E-MAIL**

E-mail the Benefit Services department at [BenefitServices.Helpdesk@corvestaservices.com](mailto:BenefitServices.Helpdesk@corvestaservices.com).

### **BY PHONE**

Call the plan's Benefit Services department whenever you have a question about your dental plan. You can reach us by calling **855-292-3709** which is located on the back of your ID card. Individuals with special hearing requirements may call 877-287-9039 to reach the TTY/TDD member care line. Benefit Services representatives are available Monday through Thursday from 8:15 am to 6:00 pm and Friday 8:15 am to 4:45 pm (EST) to help with:

- General questions
- Claims questions
- Complaints and problem resolution

### **BY MAIL**

Correspondence should be addressed to:

Corvesta Services  
ATTN: Benefit Services  
P.O. Box 12806  
Roanoke, VA 24028

## **How to Use Your Benefits**

You and your family members are covered for dental services when enrolled in your employer's plan. In most cases, this plan will pay a portion of the cost of your covered benefits (up to any plan maximums). You may be responsible for deductibles, coinsurance and in some cases, dentists charges that exceed what your plan covers. Please see the **Schedule of Benefits** in your BSG for more details about what is covered under your plan. In cases where you choose to have a more expensive service or benefit than is normally provided, or for which there is not a valid need, your plan will pay the applicable percentage of the fee for the service which is adequate to restore the tooth or dental arch to proper function. You may be responsible for the difference between what your plan pays and the dentist's fee for the optional treatment.

## **Eligible Dependents**

An employee's spouse and children are eligible to be covered under your plan. (Please see your **Schedule of Benefits** for details on the dependent age limits.) If you need to add dependents to your coverage, please see your human resources benefit administrator. Generally, dependents can be added to your coverage on the first day of the month immediately following a qualifying event as long as your plan administrator is notified in writing no later than 31 days after the qualifying event.

For information regarding eligibility, please refer to your BSG at the end of this handbook or contact our Benefit Services department at the toll-free number on your ID card.

## **Visiting the Dentist**

You may choose to go to any licensed dentist when you need dental care. Benefits reimbursements are based on covered services and benchmark charges in the geographic area in which you receive treatment. Charges for non-covered services and charges above and beyond customary benchmark charges in any given area are the member's responsibility.

## **Predetermination of Benefits**

To assist you in managing your total costs, your administrator offers what's called "Predetermination of Benefits". Dentists may submit their treatment plan to your dental administrator for a review and estimation of coverage before procedures are started. Your dental administrator advises the patient and the dentist of what services are covered and what the payment would be. The actual payment for these predetermined services depends on eligibility, any plan limitations, coordination of benefits and the remaining maximum at the time services are performed. Predetermination is optional, but it is strongly recommended for dental services expected to exceed \$250. Once the service is completed, the claim should be submitted to your dental administrator for prompt payment.

## **Filing Claims**

Most dentists file claims electronically or have claim forms on hand. If they do not file the claim for you, you may obtain a claim form from your Human Resources department.

Then follow these easy steps to ensure efficient processing:

Complete your portion of the claim form and present the form to the dentist for completion, or attach any paperwork given to you by your dentist following your visit. Mail your completed claim form to the address below.

All claims are processed in Roanoke, Virginia. Our mailing address is:

Corvesta Services  
ATTN: Claims  
P.O. Box 12806  
Roanoke, VA 24028

All claims must be submitted within twelve (12) months of the date services are completed. This is called the timely filing limitation.

## **Explanation of Benefits**

Corvesta will notify you in writing of the amount of benefits paid on your behalf and the amount that you must pay. This is called an **explanation of benefits (EOB)**. If you need another copy of your EOB for any reason, you can always request one.

If you would like to request an EOB or need further explanation, please call our Benefit Services department at 855-292-3709. Individuals with special hearing requirements may call 877-287-9039 to reach the TTY/TDD member care line.

## **Complaint and Appeals Procedures**

You have the right to file a complaint or appeal a denied claim. Please consult the BSG at the end of this handbook for details.

## **Coordination of Benefits**

If you are covered under another dental plan, your administrator will coordinate your covered benefits as described in your BSG. Among other things, coordination of benefits (COB) eliminates duplicate payments for the same dental services. Please see the BSG at the end of this handbook for details on the rules regarding which insurance plan would be considered primary and which would be considered secondary for payment purposes.

## Common Dental Terminology

Listed below are definitions for commonly used dental terms. Please also see the Definitions section in your BSG at the end of this handbook for a listing of defined contractual terms.

**Amalgam Filling** – a type of tooth filling made of silver and mercury.

**Anesthesia** – substances used to remove the effects of pain. Generally 1 of 4 types: topical anesthesia, local anesthesia, general anesthesia or neuroleptic anesthesia.

**Anterior (front) teeth** – the upper front teeth, tooth numbers 6-11; and/or the lower front teeth, tooth numbers 22-27.

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

**Board Certified** – a dentist that has been approved by the American Dental Society to practice a particular specialty. Board certified dentists have demonstrated at least 2 years of residency in a particular dental specialty and have passed an exam demonstrating education and experience to be certified in that specialty.

**Bridge** – dental work that involves supporting a replacement tooth between two healthy teeth.

**Bruxism** – clenching or grinding of the teeth.

**Caries** – clinical term for decay (cavity).

**Comprehensive or periodic oral evaluation** – evaluation and recording of the extraoral and intraoral hard and soft tissues (outside and inside of the mouth) typically including any cavities, missing or unerupted (yet to break the skin) teeth, fillings and periodontal conditions. This includes an oral cancer screening.

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

**Crowns** – an artificial 'top' made of porcelain, composite, or metal that is cemented on top of damaged teeth.

**Curettage** – a periodontal procedure which involves scraping off plaque to the bottom of the damaged gum tissue and removing the damaged gum tissue.

**Dentures** – a set of artificial teeth.

**Endodontist** – a Board Certified dentist specializing in the disease of tooth pulp.

**Fluoride** – a chemical known to strengthen tooth enamel making teeth less susceptible to decay.

**General Anesthesia** – a class of anesthesia substance or substances that are inhaled as gases. General anesthesia eliminates pain by rendering patients completely unconscious.

**Gingivitis** – stage one of early periodontal disease characterized by inflamed, reddish gum tissue which may bleed easily when touched or brushed. Untreated, gingivitis can lead to chronic periodontal disease and the instability of teeth.

**Gingivectomy** – a procedure performed by periodontist to remove diseased gum tissue.

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

**Local Anesthesia** – a class of anesthesia substance applied by injection directly to the gums or mouth tissue to provide pain relief to a local area of the mouth or gum. The patient remains alert during the procedure without the pain.

**Neuroleptic Anesthesia** – a class of anesthesia substance applied intravenously. The degree of anesthesia can be controlled from slight consciousness to totally unconscious.

**Nightguard/Occlusal Guard** – a removable acrylic appliance used to minimize the effects of grinding the teeth (bruxism) or joint problems (TMJ). Usually worn at night.

**Oral and Maxillofacial Surgeon** – Board Certified dentist who specializes in surgery of the teeth and bones of the jaw, jawbone or face.

**Orthodontist** – Board Certified dentist who specializes in correcting abnormally aligned or positioned teeth.

**Panoramic X-ray** – the x-ray machine makes a complete half circle from ear to ear to produce a complete two dimensional representation of all teeth.

**Periapical X-ray** – x-rays providing complete side views from the roots to the crowns of the teeth. Typically a complete set consists of 14-24 films with each tooth appearing in two different films from two different angles.

**Periodontist** – Board Certified dentist who specializes in gums, gum disease, tissues and structures supporting the teeth.

**Plaque** – a sticky fairly transparent film that forms on the teeth or cracks of the teeth primarily composed of undigested food particles mixed with saliva and bacteria. Left alone, plaque eventually turns into tartar or calculus.

**Pontic** – the part of a bridge that replaces the missing teeth.

**Prophylaxis** – removal of plaque, tartar and stains from teeth.

**Prosthetics** – dental implants or artificial teeth.

**Prosthodontist** – Board Certified dentist who specializes in the replacement of missing teeth by bridges and dentures.

**Root Canal** – a four step process required when the inner pulp of the tooth is irreversibly damaged. Step 1 involves removing all of the inner pulp of the tooth. Step 2 involves cleaning and smoothing the inside of the tooth. Step 3 involves filling the tooth with an inert material. Finally, an artificial crown is placed on top of the tooth.

**Root Planing** – the procedure of scraping plaque off of teeth below the gum line or on the root of the tooth.

**Sealants** – a substance applied to the biting surface of teeth to protect them from decay.

**Splints** – devices used when an otherwise healthy tooth has become loose due to advanced periodontal disease to prevent movement.

**Topical Anesthesia** – ointment or gel applied directly to the gums or mouth tissue to provide pain relief on the immediate surface of the tissue; often applied to reduce the pain associated with needle pricks or to reduce pain and discomfort of mild infections or irritations on the gum or in the mouth.

**TMJ or Temporomandibular Joint Disorder** - the joint formed where the lower jaw bone attaches to the head. TMJ refers to the general class of disorder affecting the bones and muscles of this region. Symptoms range from tenderness and swelling to headaches and neck and back aches. Generally, a clicking or popping sound is heard when the jaw is opened or closed.

# **BENEFIT SUMMARY GUIDE**

**Dental Plan Sponsored by  
Botetourt County Board of Supervisors**

**Administered by  
Corvesta Services**

Roanoke, Virginia 24018-8542

Telephone: 855-292-3709

TTY/TDD: 877-287-9039

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This is your Benefit Summary Guide. It is also referred to as your BSG. This BSG is part of your Group's Contract. The entire agreement consists of the following: the Benefit Summary Guide, the Group contract and any amendments and attachments. In all cases, the Benefit Summary Guide including the **Schedule of Benefits** and Benefit Limitations will be the controlling document. All of the provisions in this BSG are subject to the terms, conditions, and limitations of your Group's contract.

Your employer sponsors your coverage, and your plan is administered by Corvesta Services. In most cases, this plan will pay a portion of your Covered Benefits' costs. You may be responsible for Deductibles, Coinsurances, and some Dentists' charges that exceed what the plan pays.

**NOTE:** Words that are capitalized indicate that they are a defined term. Please refer to the Definitions section, for more detailed information on defined terms.

## PLAN PROVISIONS

The following is a description of benefits offered under your Group dental plan.

If you have any questions about your benefits or need additional information, you can contact our Benefit Services department by calling 855-292-3709. Individuals with special hearing requirements may call 877-287-9039 to reach the TTY/TDD member care line.

NOTE: The Benefit Period during which the Annual Maximum(s) and Deductible (if any) is accumulated is January 1 to December 31 each year.

Plan Sponsor:	Botetourt County Board of Supervisors
Group Number:	1000
Eligible Class:	All active full-time and all qualified part time employees
Eligibility:	All active full-time employees Part-time employees working 20 hrs/wk for at least 1 year
Eligibility Waiting Period:	First of the month following 30 days of employment
Dependent Child Age Limit:	Up to age 19; Up to age 25 if a full-time student
Benefit Waiting Period:	Applies to all new hires Applies to all new enrollees during annual enrollment Pro-rated waits apply to new hires in 2011
Annual Enrollment:	Every November, for a December 1 effective date Applicable waiting periods apply to new enrollees
Individual Deductible:	\$25 per calendar year
Family Deductible:	\$75 per calendar year
Annual Dental Maximum:	\$1000 per calendar year per member

## SCHEDULE OF BENEFITS

Benefit Category	Plan Payment*	Deductible Applies	Benefit Waiting Period**
Diagnostic & Preventive Care	100%	No	None
Palliative Treatment	100%	No	None
Basic Restorative Services	80%	Yes	None
General Services	80%	Yes	None
Endodontics	80%	Yes	None
Periodontics	80%	Yes	12 months
Oral Surgery	80%	Yes	None
Crowns, Inlays & Onlays	50%	Yes	12 months
Prosthodontics	50%	Yes	12 months

\*Payment is based on benchmark charges for providers in the same region. Charges that are higher than benchmark charges could result in balance billing from the provider.

\*\*Waiting period applies to all new hires and all new enrollees in the plan at each annual enrollment. Pro-rated waiting periods will apply only for new hires in 2011.

## **COVERED DENTAL SERVICES**

### **Diagnostic & Preventive Care**

**Services for the purpose of preventing dental disease or to determine the cause of a dental disease.**

- Routine Oral Evaluations, limited to two per calendar year
- X-rays (dental radiographs)
  - Full mouth or panorex x-ray, limited to once every 36 months
  - Bitewings, limited to 4 horizontal films or 8 vertical films twice per calendar year
  - Diagnostic x-rays, except in connection with orthodontic treatment
- Professional cleaning, scaling and polishing teeth (prophylaxis), limited to two per calendar year
- Fluoride treatment (topical application), limited to two per calendar year for participants up to age 19
- Sealants, limited to one per unrestored permanent molar for participants up to age 14
- Space maintainers for participants up to age 19

### **Palliative Treatment**

- Emergency treatment to relieve dental pain except when performed in conjunction with definitive dental treatment

### **Basic Restorative Services**

**Artificial replacement of part of a tooth that is damaged by dental disease. All tooth preparation including adhesive, liners and bases are included as part of the restoration.**

- Amalgam restorations, limited to once per surface per tooth in any calendar year
- Pin retention, per tooth, in conjunction with the restoration
- Composite restorations, limited to once per surface per tooth per calendar year
- Simple tooth extraction

### **General Services**

- Intravenous sedation
- General anesthesia
- Injection of antibiotic drugs
- Stainless steel crowns limited to one per tooth in a 60 month period and not to be used as a temporary crown

### **Endodontics**

**Services to prevent, diagnose and treat diseases and injuries that affect the tooth and dental pulp.**

- Root canal therapy including treatment plan, clinical procedures, pre and post-operative radiographs and follow up care
- Direct pulp cap
- Apicoectomy / periradicular services
- Apexification / recalcification
- Retrograde filling
- Root amputation / hemisection
- Therapeutic pulpotomy
- Gross pulpal debridement

## **Periodontics**

**Services to treat diseases of the gum and tissues, limited to two exams per Calendar Year in addition to regular cleanings.**

- Periodontal scaling and root planning, limited to one time per quadrant per calendar year
- Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to one time per calendar year
- Gingivectomy or gingivoplasty, limited to one time per quadrant per calendar year
- Gingival flap procedure (includes root planning), limited to one time per quadrant per calendar year
- Osseous surgery, including flap entry with closure, limited to one time per quadrant per calendar year
- Osseous grafts, limited to one time per site per calendar year
- Soft tissue grafts (includes donor site)

## **Oral Surgery**

**Operative and cutting procedures for the treatment of specific conditions.**

- Surgical tooth extractions
- Alveoloplasty
- Vestibuloplasty
- Other dentally necessary surgical procedures

## **Crowns, Inlays & Onlays**

**Major restorations of damage from extensive disease or fracture, limited to once per tooth per 60 months.**

- Prefabricated post and cores
- Cast post and cores
- Crown, inlays/onlays repairs
- Recementation of inlays/onlays and crowns

Benefits include the replacement of a lost or defective crown whether placement was under this Plan or under any prior dental coverage and even if the original crown was stainless steel.

Benefits are not provided for the replacement of dentures, crowns, inlays, onlays, removable or fixed prostheses and dental restorations due to theft, misplacement or loss; or for replacement of dentures, removable or fixed prostheses, and dental restorations for any other reason within 60 months after receiving such dentures, prostheses or restorations.

## **Prosthodontics**

**Services to restore and maintain the oral function and health of a patient by replacing missing tooth and surrounding tissues by artificial means. Covered Services include bridges, partial dentures and complete dentures.**

- Initial installation of removable complete, immediate or partial dentures (including and adjustments, relines or rebases during the 6 month period following installation), limited to once in any 60 month period, whether placement was under this Plan or under any prior dental coverage
- Replacement of complete or partial dentures, if the appliance is 60 months old or older and cannot be made serviceable
- Adjustments, limited to 3 times per appliance per calendar year
- Repairs
- Addition of tooth or clasp (unless additions are completed on the same date as replacement partials/dentures), limited to a lifetime maximum of once per tooth
- Denture rebase and reline procedures, limited to one in any 36 month period

## LIMITATIONS

The following limitations apply to all contracts and contain Dental Services that may not be a Covered Benefit under this Benefit Summary Guide. Please refer to the **Schedule of Benefits** for a complete listing of Covered Benefits under this Benefit Summary Guide.

- Oral exams are limited to twice in a Calendar Year.
- Regular cleanings are limited to twice in a Calendar Year.
- Periodontal cleanings are limited to twice in a Calendar Year, not subject to the limitation for regular cleanings.
- Full mouth debridement is a Covered Benefit when an Enrollee has not had a cleaning or scaling and root planing within 36 months of the full mouth debridement.
- Full mouth debridement is limited to once per calendar year.
- Fluoride applications are limited to twice in a Calendar Year for Dependents under the age of 19.
- Bitewing X-rays are limited to twice in a Calendar Year; limited to a maximum of 4 bitewing films or 8 vertical films in one visit.
- Full mouth/panorex X-rays are limited to once in a three year period.
- Sealants are limited to non-carious, non-restored 1<sup>st</sup> and 2<sup>nd</sup> permanent molars for Dependents under the age of 14, one application per tooth.
- Amalgam (silver) and composite (white) fillings are limited to once per surface in a 24-month period.
- Space maintainers are limited to once per lifetime for Dependent children under the age of 19.
- Retreatment of root canal therapy is a Covered Benefit two years after initial treatment.
- Replacement of an existing crown is a Covered Benefit once every five years per tooth, and when the existing crown is not serviceable.
- Replacement of an existing prosthetic is a Covered Benefit once every five years, and when the existing prosthesis is not serviceable.
- A 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.
- Stainless steel crowns are limited to primary (baby) teeth.
- Fixed bridges or removable partials are limited to Dependents over the age of 15.
- Crowns are a Covered Benefit when the tooth damaged by decay or fracture cannot be restored by amalgam or composite restoration.
- Temporary prosthetic devices are not a separate benefit. Any charge for these devices is included in the fee for the permanent device.

## 1.0 ELIGIBILITY AND ENROLLMENT

You are eligible for coverage, if you:

- Meet the Group's eligibility requirements, and
- Properly enroll in the Group's dental plan.

Your employer will inform you of your effective date under the dental plan.

The following individuals are eligible for coverage:

### **Subscriber**

Eligible Subscriber includes:

- Any employee who satisfies the Group's eligibility requirements and is determined to be eligible by the Group; and
- Has completed any new hire waiting period (if applicable) outlined in the **Schedule of Benefits**.

### **Dependent**

A Dependent is any person who is a member of the Subscriber's family, who meets all applicable eligibility requirements under the Group's dental plan and has properly enrolled.

Eligible Dependent includes:

Subscriber's spouse

Subscriber's children, including:

- A newborn, natural child or a child placed with Subscriber for adoption;
- A stepchild;
- Children within the age limit requirement(s) outlined in the **Plan Provisions**;
- A dependent child who is incapable of self-support because of a physical or mental incapacity that began prior to the age limit requirement.

If applicable, to qualify as a full-time student, the dependent must be attending a recognized secondary school, trade school, college or university on a full-time basis. Your administrator will ask for proof of full-time student status. If a child is not capable of self-support due to a severe physical or mental handicap that began before the limiting age, your administrator will ask for a physician's certification of the dependent's condition.

### **Other Individuals**

As determined to be eligible by the Group.

### **Military Leave**

Your plan will cover any Subscriber who is on active duty as required under the Uniformed Services Employment and Reemployment Act of 1994 (USERRA). Subscribers performing military duty of more than 30 days may elect to continue employer sponsored health care for up to 24 months; however, the Subscriber may be required to pay for this coverage. For military service of less than 31 days, health care coverage is provided as if the service member had remained employed.

Even if you do not continue coverage during military leave through your employer, your administrator will reinstate coverage if you are eligible under the Group's Contract.

## Changing Coverage

The coverage category that the Subscriber selects cannot be changed until the Group's next Annual Enrollment Period. However, a Subscriber may change coverage categories before the Annual Enrollment Period due to a qualifying event (i.e., marriage, birth, loss of other coverage). It is the Subscriber's responsibility to notify the Group within 31 days of any changes in his or her eligibility status or the status of a Dependent (i.e., divorce).

Regardless of when you enroll, you may have to serve Benefit Waiting Period(s) before you receive Covered Benefits. Please refer to the **Schedule of Benefits** for more information about Benefit Waiting Period(s).

## 2.0 COVERED BENEFITS, DEDUCTIBLE AND BENEFIT WAITING PERIOD

Dental Services will be provided as a Covered Benefit if it is determined that the service rendered was:

1. Necessary and customary for the diagnosis and/or treatment of your condition;
2. The Dental Service is identified as a Covered Benefit in the **Schedule of Benefits**; and
3. You meet the eligibility requirements under the Contract.

See the **Schedule of Benefits** for a listing of Covered Benefits, applicable Coinsurances, Deductibles, limitations and any benefit waiting periods that might apply.

A Dentist must provide all Covered Benefits. There are five exceptions. A qualified dental hygienist may provide Covered Benefits for:

1. Cleaning or scaling your teeth,
2. Applying fluoride directly (i.e. "topically") to your teeth,
3. Administering oral anesthetics topically,
4. Applying antimicrobial agents topically for the treatment of periodontal pocket lesions, and
5. Administering analgesia and anesthesia.

To be covered, the dental hygienist's services:

1. Must be supervised and guided by a Dentist whose services would also be covered under this Contract;
2. Must be provided in accordance with generally accepted dental practice standards and the laws and the regulations of the state or other jurisdiction in which the services are provided; and
3. Are subject to all other terms, conditions, exclusions, and limitations in the Contract.

Your administrator may review any claim before it is paid. The reviewer may review the claim to determine generally accepted dental practice standards. Your administrator uses its own standard processing policies to determine which Dental Services are Covered Benefits. Covered Benefits are subject to your administrator's processing policies, and your plan's limitations and exclusions.

## **Deductibles, Benefit Maximums, and Coinsurances**

Your Deductibles and Benefit Maximums are listed in the **Plan Provisions**.

Deductibles are the dollar amounts you are responsible to pay for covered dental expenses before your administrator makes payment. This amount will not be reimbursed by your plan. After any deductible amount has been paid, your plan will pay for Covered Benefits at the percentage rate shown in the **Schedule of Benefits**.

Benefit Maximum is the total dollar amount that your plan will pay for Covered Benefits during a Benefit Period. Amounts over the Benefit Maximum will not be covered. Once the Benefit Maximum is reached you pay 100% of the cost of any Dental Service received. Certain services may have a separate Benefit Maximum.

Coinsurance is a fixed percentage rate of the cost of a Covered Benefit where you may be responsible for sharing the cost for Covered Benefits with your plan. The percentage of the Coinsurance that your plan will pay for each benefit class is shown on the **Schedule of Benefits**. The Dentist may require you to pay your share of any Coinsurance at the time you receive the Covered Benefit.

### **Benefit Waiting Period**

A Benefit Waiting Period is the amount of time that must pass before you are eligible for Covered Benefits. Refer to the **Schedule of Benefits** to see if a Benefit Waiting Period applies to a specific Dental Service. The **Schedule of Benefits** will tell you the length (if any) of the Benefit Waiting Period for that service.

### 3.0 EXCLUSIONS

The following are not Covered Benefits **unless specifically identified** as a Covered Benefit in the **Schedule of Benefits**:

- Services or supplies that are not Dental Services; also services not specifically listed as covered in the **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.
- A Dental Service that your plan administrator, in 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, your administrator 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 for illnesses, injuries or other conditions you are eligible for coverage under your hospital, medical/surgical, or major medical plan.
- Dental Services started or rendered before the date enrolled under this BSG. Also, except as otherwise provided in this BSG, benefits for a course of treatment that began before you are enrolled under this BSG.
- Except as otherwise provided for in this BSG, Dental Services provided after the date you are no longer enrolled or eligible for coverage under this BSG.
- Except as otherwise provided for in this BSG, prescription and non-prescription drugs; pre-medications; preventive control programs, oral hygiene instructions, and relative analgesia.
- General anesthesia when less than three (3) 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; 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 your administrator'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 BSG 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 your administrator determines are for correcting congenital malformations; also, cosmetic surgery or dentistry for cosmetic purposes.

- Experimental or investigative dental procedures, services, supplies as well as services and/or procedures due to complications thereof. Experimental or investigative procedures, services or supplies are those which, in the judgment of the administrator: (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 your administrator, in 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. Your administrator bases its payment on the Plan Allowance for the more comprehensive code, not on the Plan Allowance for the underlying component codes.
- Services billed under a Dental Service procedure code that your administrator, in 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. Your administrator 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 benchmark charge for the geographic area of service.

#### **4.0 OTHER PAYMENT RULES THAT AFFECT MY COVERAGE**

##### **Alternate treatment**

After consulting with your Dentist, you may select a more expensive Covered Benefit than the one that your plan determines is necessary or customary for the diagnosis or treatment of your condition. Your plan will only pay the amount for the necessary or customary Covered Benefit. You may be responsible for the entire balance of the Dentist's fee for the more expensive Covered Benefit.

##### **Dental Services requiring multiple visits**

Some Dental Services take multiple visits to complete. Examples include crowns, bridges, removable prosthetics, and endodontic services. Your plan only pays for Covered Benefits that require multiple visits after the entire course of treatment is completed. Your date of service is the completion date for all these services.

In addition, Dental Services are not Covered Benefits if you receive the service after your coverage under this Contract ends. However, there are exceptions for Dental Services that require multiple visits. Examples of these type services include, but are not limited to:

- Fixed bridgework and a full or partial denture, only if the Dentist takes first impressions or fully prepares the abutment teeth before the date your coverage under this BSG ends;
- A crown, only if the Dentist fully prepares the tooth to be treated before the date your coverage under this BSG ends; and
- Root canal therapy, only if the Dentist opens the pulp chamber of your tooth before the date your coverage under this BSG ends.

**NOTE:** In most cases, the Dental Service has to be completed within 30 days after the initial date of the service.

## **Incomplete treatment**

If a Dentist starts a course of treatment and it is completed by a different Dentist, your plan will split its payment between the Dentists in the manner that it determines is reasonable and equitable to both Dentists. At its sole discretion (subject to any and all internal and external appeals available to you), your administrator will determine how to split payment between the Dentists. You may be responsible for any unpaid balances if the Dentists do not agree.

## **5.0 WHEN COVERAGE ENDS**

Coverage ends on the day that you cease to be eligible under the Group dental plan.

Examples of when an Enrollee may cease to be eligible:

- for the Subscriber, when you leave the company;
- for a Spouse, when the employee and spouse divorce;
- for a child, when the child reaches the age limit for coverage as outlined in the **Schedule of Benefits**; or
- for a handicapped Dependent, when no longer handicapped.

Listed below are three methods for continuing Enrollee coverage after termination. The availability of these methods will depend upon the terms and conditions of your Group Contract. Your Group Administrator can provide information about options once an Enrollee is no longer eligible under the Group dental plan. They can also answer questions related to eligibility, enrollment and coverage periods.

You and your Dependents may be eligible to continue coverage under the following conditions:

- continuous Group coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), if your company is subject to COBRA; or
- continuous Group coverage under state law;

## **COBRA continuation of coverage**

If your employer had 20 or more employees in the previous calendar year, you and your covered Dependents may elect to continue coverage if you meet the Qualifying Events described under COBRA. If you or your covered Dependents would normally lose eligibility for coverage because of a Qualifying Event, you may choose to continue coverage under your employer's Group dental plan. You must pay for this coverage on your own. The period a COBRA beneficiary (including you) would be eligible to continue coverage depends on the type of Qualifying Event the Enrollee has experienced.

## **Continuous coverage under state law (12 months)**

You may be able to continue coverage under your Group's dental plan for a period of 12 months after losing eligibility under the Group's dental plan. For those covered under COBRA, the 12 month state continuation is not applicable. Benefits under a continuation dental plan will match your current Group dental plan benefits. Coverage will continue for the 12 month period without further evidence of insurability, if:

- the Enrollee meets enrollment requirements for the state continuation plan, and
- the Enrollee applies within 60 days from the last day of coverage under the Group plan.

Under the state continuation, you will make monthly premium payments to the Group for as long as the coverage is active.

## **6.0 CLAIMS, APPEALS AND GRIEVANCES**

The following is a description of how a claim for benefits is processed. A claim is any request for a plan benefit made by you. The times listed are maximum times only. A period begins when you file the claim. Days mean calendar days.

### **Filing a Claim**

You or your dentist may submit claims to:

Corvesta Services  
ATTN: Claims  
P.O. Box 12806  
Roanoke, VA 24028

You must submit all claims for dental benefits within twelve (12) months of the date services are completed. This is called the timely filing limitation. There are different types of claims and each one has a specific timetable for either approval of the claim, a request for more information to process the claim, or denial of the claim.

Following the submission of a claim, you may receive an adverse benefit determination. An appeal is a complaint about a denied claim or an adverse benefit determination.

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

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

The individual is not eligible to participate in the dental plan; or

Your administrator determines that a benefit or service is not a Covered Benefit because:

- it is not included in the list of Covered Benefits,
- it is specifically excluded,
- a benefit limitation under the dental plan has been reached,
- is not necessary or customary for the diagnosis or treatment of your condition [Dental Necessity].

### **Notice to Claimant of Adverse Benefit Determinations**

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

### **Authorized Representative**

You may authorize a representative to act on your behalf in pursuing a claims review or claims appeal. Your administrator may require that you identify your authorized representative for us in writing in advance. For an urgent care claim, you may designate a dental care professional, who is knowledgeable about your dental condition, to act on your behalf. We will deal directly with your authorized representative, rather than you, for matters involving the claim or appeal.

## **Appeals of Adverse Benefit Determinations**

Benefit Service Representatives are available during regular business hours to answer your questions. You can reach us at 855-292-3790. Individuals with special hearing requirements may call 877-287-9039 to reach the TTY/TDD member care line. If a matter cannot be resolved to your satisfaction based on a telephone call, an appeals process is available to you. It is mandatory that you use this appeals process before deciding to take any legal action against your plan.

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

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

You may submit written comments, documents, records, and other information relating to the claim. You may request, and your administrator will provide to you free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim.

The appeal will be conducted without deferring to the original adverse decision. The individual who conducts the appeal will not be the person who made the initial decision or that person's subordinate. Your administrator will consult a dental care professional who has appropriate training and experience in the field of dentistry involved if dental judgment is required. The dental care professional whom we consult for the appeal will not be the person whom we consulted in making the initial decision or that person's subordinate. Upon request, we will identify the dental professional whom we consulted, whether or not we relied on his or her advice in reaching our adverse decision.

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

Corvesta Services  
ATTN: Appeals  
P.O. Box 12806  
Roanoke, VA 24028

## **Grievances**

Your administrator would like Enrollees to be completely satisfied with the dental care and services they receive but recognize that there are times an Enrollee may have questions, concerns or complaints. If you are dissatisfied with the service received from Corvesta Services, you may file a grievance. A grievance is a complaint about quality of care or service.

Please send your grievance to:

Corvesta Services  
ATTN: Grievances  
P.O. Box 12806  
Roanoke, VA 24028

## 7.0 COORDINATION OF BENEFITS (COB) WITH OTHER PLANS

You and your family members may have coverage for Dental Services by more than one Plan. For instance, you may have coverage under this Plan as an employee and under another Plan as a dependent. The coordination provision determines how the Plan pays benefits when you have coverage under more than one Plan. Among other things, coordination of benefits eliminates duplicate payments for the same Dental Services. Please note you can never receive **more** than your actual out of pocket expense for a dental procedure or service (i.e. You cannot claim the full amount of your out of pocket expense under both Plans. You can only claim under the second Plan the portion that the first Plan did not cover.)

**Definitions:** The following definitions apply to this COB section only:

**Plan** means any of the following that provides dental benefits or services: (a) any dental care contract sponsored by your employer; (b) dental or health insurance policy, contract or other arrangement in which a dental service benefit is offered or available; (c) a medical or dental HMO; (d) labor management trustee plan, union welfare plan; (e) employer organization plan; (f) employee benefits plan; (g) or tax-supported or government program to the extent that coordination of benefits is permitted by law. A "Plan" can be either insured or self-insured. It may also be an ERISA or a non-ERISA plan. For the purposes of this section only, the term "Plan" does not mean an individually underwritten and issued policy, contract or other arrangement that provides for accident and sickness benefits exclusively and the patient, patient's guardian, or family member pays the entire premium.

**Primary Plan** is the Plan responsible for determining and paying benefits first.

**Secondary Plan** is the Plan or Plans responsible for determining and paying benefits after the Primary Plan determines and pays its benefits.

The first step is to determine which Plan is the "Primary Plan" and which is the "Secondary Plan", but no Plan pays more than it would have without this provision. The guidelines below determine which Plan is primary and which is secondary:

- The Plan without a coordination provision is always the Primary Plan.
- Your medical benefits Plan may provide coverage for a few Dental Services covered by your plan. In this case, your medical benefit Plan is Primary. Extraction of impacted wisdom teeth and oral surgery are examples of services sometimes covered under both medical and dental benefit Plans.
- If both Plans have a COB provision, the Plan covering the patient as an employee rather than as a dependent is primary.
- If a child is covered under both parents' Plans:
  1. The Plan of the parent whose birthday falls earlier in the year is primary and the Plan of the parent whose birthday falls later in the year is secondary.
  2. If both parents have the same birthday, the Plan that covered the parent longer is primary.
  3. If the other Plan does not have this "birthday rule", then the above will not apply and other Plan's COB provision will determine the order of benefits.
- When parents are separated or divorced, the Primary Plan is determined in this order:
  1. When a court order requires one parent to be financially responsible for a dependent child's dental care expenses, that parent's Plan is the Primary Plan for that dependent child;
  2. If there is no such court order, the Plan of the natural parent with legal custody of the child;
  3. After one parent re-marries or both parents re-marry, the Plan of the natural parent with legal custody is the Primary Plan. The Plan of the child's custodial stepparent is the

Secondary Plan. Plan benefits for the child's parent without legal custody are determined third. The non-custodial stepparent's Plan benefits are determined fourth.

- The Plan that covers the patient as a working employee (or dependent of a working employee) is the Primary Plan. The Plan that covers the patient as a former or retired employee (or his or her dependent) is the Secondary Plan.
- When none of the other rules apply, the Plan that has covered the patient for the longest uninterrupted period is the Primary Plan.
- When the order of benefit determination cannot be determined, then the other Plan is primary.
- When the order of benefit determination cannot be determined and if one of the Plans is a dental HMO, then the dental HMO is primary.

As the Primary Plan, this Contract's benefits are determined as though the other Plan did not exist. As the Secondary Plan, this Contract's benefits will be coordinated so that the sum of all benefits payable by all of the Plans (including this Plan) does not exceed what your plan would have allowed in the absence of this COB section. For example, when your plan is the Secondary Plan, your plan's obligation to provide Covered Benefits under this Contract is satisfied if the Primary Plan pays the same amount or more than your plan would have allowed if benefits had not been coordinated. Even if you have not submitted a claim with the other Plan, your plan may coordinate benefits with the other Plan. In all cases, any applicable deductible will reduce the amount owed by your plan under this COB section. When a Plan provides benefits in the form of services rather than payment, your plan will assign a reasonable cash value to each Covered Benefit. This cash value is considered a benefit payment.

For surgical dental services, if your Dentist has an agreement with the Primary Plan to accept a lower allowance than your plan's allowance as payment in full for a Covered Benefit, your plan coordinates benefits using the Primary Plan's allowance rather than your plan's allowance.

Your Covered Benefits will not increase because benefits are coordinated. Your plan will never pay more than it would have paid in the absence of this section. If your Primary Plan is a medical or dental HMO, your plan's only obligation as the Secondary Plan is your Deductible or Copayment for the HMO coverage, if any. You should provide your plan administrator with all information about coverage available from the other Plan(s). By accepting coverage under this Plan, you authorize your plan to obtain from, and release to, any other Plan all the information necessary to coordinate benefits. You also authorize your plan administrator to recover from any other Plan, your Dentist, or you the amount of Covered Benefits that your plan has paid in excess of its obligations under this COB section.

## 8.0 DEFINITIONS

This is the definitions section. The following terms used in the Contract, including this BSG, have these meanings:

- **Annual Enrollment Period** is the period designated by the Group for employees to elect coverage for the upcoming Benefit Period.
- **Benefit Maximum** is the total dollar amount that your plan will pay for the listed Covered Benefits during the specified Benefit Period.
- **Benefit Period** is a specified period to incur Covered Benefits in order for them to be eligible for payment. This is also the specified period of time that your Deductible (if any) and your Benefit Maximum (if any) is calculated.
- **Benefit Summary Guide (BSG)** means this booklet and any amendments, riders, or endorsements to this booklet that your plan issues. This booklet is part of your Group's Contract.
- **Benefit Waiting Period** is the period of time that must pass after enrolling under the plan before an Enrollee can start receiving Covered Benefits.
- **Contract** means the Group's Dental Care Contract, including this BSG and BSG schedules, addenda, and amendments made a part of the Group's Dental Care Contract.
- **Coinsurance** is a portion of the Dental Services the Enrollee is responsible for paying. It is usually a percentage of the Plan Allowance the Enrollee pays directly to the Dentist for Covered Benefits after meeting any applicable deductible.
- **Covered Benefits/Covered Services** means the Dental Services covered under this BSG subject to its terms, conditions, exclusions, and limitations of the Contract.
- **Deductible** is a fixed dollar amount the Enrollee is responsible to pay before your plan will begin covering the cost of Covered Benefits.
- **Dental Necessity** means for a Covered Benefit that your administrator, in its sole discretion (subject to any and all internal and external appeals available to you), determines is necessary or customary for the diagnosis or treatment of your condition. In making this determination, your administrator will take into account whether a prudent dentist would (a) provide the service or product to a patient to diagnose, evaluate, prevent or treat an injury, disease or (b) its symptoms in accordance with generally accepted dental practices of the professional dental community and within their professional guidelines.  
  
Dental Necessity includes, but is not limited to, treatments involving dental structures and pathology, which while rarely medically necessary, are essential to resolve the condition of dental disease. A medically necessary situation as it relates to dental therapies is one where failure to provide the Dental Service(s) would result in harmful effects to one's overall health status or are necessary to sustain life.
- **Dental Services** means care and procedures provided by a Dentist for the diagnosis and treatment of dental disease or injury. Not all Dental Services are Covered Benefits.
- **Dentist** means a person with a valid, unrestricted license to practice dentistry in the state or other jurisdiction in which the Enrollee receives the Dental Service.
- **Dependent** is any person who is a member of the Subscriber's family, who meets all applicable eligibility requirements under the Group's dental plan and has properly enrolled.
- **Effective Date** is the date coverage begins for an Enrollee provided they have properly enrolled.
- **Enrollee** means the Subscriber's Dependents, as well as the Subscriber, who are entitled to coverage under the Group's dental plan and has properly enrolled.
- **Group** means the Subscriber's employer.

- **Predetermination Plan** is a detailed description of Dental Services that your Dentist prepares and your administrator reviews, before receiving Dental Services. A Predetermination Plan helps to determine which Dental Services are Covered Benefits and informs you what your liability may be.
- **Qualifying Event** means a change in your family, employment or group coverage status which would affect your benefits under the Group's dental plan due to one or more of the following:
  1. Marriage;
  2. Birth, adoption or placement for adoption of a Dependent child;
  3. Divorce or marriage annulment;
  4. Death of a Dependent;
  5. A change in your or your Dependent's employment status if it causes you or your dependent to gain or lose eligibility for coverage. Such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule.
- **Schedule of Benefits** is the document outlining the Covered Benefits under your dental plan.
- **Subscriber** is the Group's employee who is entitled to coverage under the Group's dental plan and has properly enrolled.
- **We, Us, or Our** refers to Corvesta Services.
- **Your Dental Administrator or Your Administrator** means Corvesta Services.
- **Your Plan Sponsor** means Botetourt County Board of Supervisors.