GLOSSARY OF DENTAL TERMS & INSURANCE TERMS

INSURANCE TERMS

ACA: The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148).

Adverse determination: means a decision by the Plan or a representative of the Plan to deny, reduce, or modify the availability of any dental care services, because your condition failed to meet the requirements for coverage based on necessity, appropriate- ness of care, level of care, or effectiveness.

Agreement: refers to the Account Dental Service Agreement, a contract between the Plan and the Plan Sponsor that provides benefits for dental services.

The Account Dental Service Agreement includes the Subscriber's Certificate, Schedule of Benefits, Group Application, Enrollment Form, rates identified in Attachment A, and any applicable Riders, Endorsements and Supplemental Agreements.

Appeal: a protest filed by a Covered Individual or a health care provider with the Plan under its internal appeal process regarding a coverage decision concerning a Covered Individual.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe.

For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Co-payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Coverage decision: an initial determination by the Plan, or a representative of the Plan that results in noncoverage of a health care service. Coverage decision includes nonpayment of all or any part of a claim but does not include an adverse determination as defined above.

Covered dependents: See Family Coverage definition.

Covered individual: a person who is eligible for and receives dental benefits. This usually includes subscribers and their covered dependents.

Date of service: The actual date that the service was completed. With multi-stage procedures, the date of service is the final completion date (the insertion date of a crown, for example).

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is

$1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. Effective date: the date, as shown on the Plan's records, on which the subscriber's coverage begins under this Agreement or an amendment to it.

Emergency medical condition: a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867 (e)(1)(B) of the Social Security Act, 42 USC section 1395dd(e)(1)(B).

Emergency dental care includes treatment to relieve acute pain or control dental condition that requires immediate care to prevent permanent harm.

Family coverage: coverage that includes the Plan Sponsor's eligible employees, their spouse and de- pendent children up to and including twenty-six (26) years of age. You or your spouse's adopted children are covered from the date of adoptive or parental placement with an insured subscriber or plan enrollee for the purpose of adoption, children under testamentary or court appointed guardianship, other than temporary guardianship of less than twelve (12) months duration, and grandchildren in your court-ordered custody who are dependent on you are also covered.

Upon the attainment of the limiting age, coverage as a Dependent shall be extended if the child is and continues to be both (1) incapable of self-support by reason of intellectual disability or physical handicap, and (2) chiefly dependent upon the subscriber for support and maintenance, until such time as the coverage of the subscriber upon whom the child is dependent terminates. Subscribers must notify the Plan and provide medical documentation to support this continued coverage through the Plan Sponsor within seventy-two (72) days of the child's qualifying birthday.

Fee Schedule: the payment amount for the services that may be provided by Participating and Non-participating Dentists under this Agreement and is on file with the Virginia Bureau of Insurance. Benefits are payable in accordance with the terms and conditions of the applicable Schedule of Benefits attached to this Agreement and in effect at the time services are rendered.

Filing date: the earlier of a.) five (5) days after the date of mailing; or b.) the date of receipt.

Fracture: the breaking off of rigid tooth structure not including crazing due to thermal changes or chipping due to attrition.

Health care provider: any hospital or person that is licensed or otherwise authorized in the Commonwealth of Virginia to furnish health care services.

Health care service: the furnishing of a service to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

Individual (or single) coverage: coverage that includes only the subscriber.

Inquiry: any question or concern communicated by the Covered Individual or on the Covered Individual's behalf, which has not been the subject of an adverse determination.

Medically Necessary: Health care services or sup- plies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Non-participating Dentist: a licensed dentist who has not entered into an agreement with the

Plan to furnish dental services to its covered individuals.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non- preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Open enrollment: a period during which an organization allows persons not previously enrolled in the dental plan to apply for dental plan membership.

Out-of-Pocket Limit: The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Participating Dentist: a licensed dentist who has contracted with the Plan to furnish dental services to its Covered Individuals.

Participating Dentist Contract: contract between the Plan and a Participating Dentist.

Plan Sponsor: the person or organization that is the representative of a group plan. In the case of an employment group subject to the Employee Retirement Income Security Act of 1974 (ERISA, as amended, the employer is the Plan Sponsor designated under that act. The Plan Sponsor is the agent of its employees and is not the agent of the Plan. The Plan Sponsor sends to us the subscription charge due from its subscribers and receives all notices from the Plan to the subscribers. The Plan will send the Plan Sponsor any subscription refund due to the subscribers. It is the Plan Sponsor's responsibility to notify subscribers of changes.

Plan Year: a consecutive 12-month period during which the Plan provides benefits under this Agreement. A Plan Year may be a calendar year or otherwise.

Qualified Employer: has the meaning ascribed to the term in 45 C.F.R. § 155.20.

Schedule of Benefits: the part of this Agreement which outlines the specific coverage in effect as well as the amount, if any, that Covered Individuals may be responsible for paying towards their dental care.

Schedule of Maximum Covered Charges: see Fee Schedule.

Subscriber: an employee or member certified by the Plan Sponsor, who is eligible to receive dental benefits. A parent or guardian enrolling a minor dependent, including under a child-only plan, assumes all of the subscriber responsibilities for the minor dependent.

The Plan: refers to DentaQuest Insurance Company (DentaQuest)

Utilization Review: a system for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a patient or group of patients.

Service Area: The Service Area is comprised of the counties and independent cities.

DENTAL TERMS

Amalgam "Silver" Filling: A metal restoration that has a silver-like color used to fill cavities in teeth caused by decay.

Anesthesia (local): A drug used by a dentist to put your mouth to sleep so that you don't feel any pain during dental procedures.

Bridge: A prosthetic replacement of one or more missing teeth.

Cavity: A hole in one of your teeth caused by decay.

Crown: Also called a cap, a lab fabricated false tooth used to restore a tooth that has heavy decay, a fracture or a root canal.

Examination/Oral Evaluation: A thorough examination of the hard and soft tissues of the oral cavity and surrounding structures.

Extraction: Removal of a tooth.

Fluoride: A substance applied to teeth after a cleaning is performed. Fluoride helps prevent tooth decay by stopping the breakdown of enamel.

Gingivitis: The inflammation of your gums. The first sign of gum disease.

Impacted Tooth: A tooth that is unable to break through the gums.

Malocclusion: Improper alignment of biting or chewing surfaces of upper and lower teeth.

Medically Necessary Orthodonture means for Members under the age of 19, a severe handicapping malocclusion as defined by the state.

Plaque: A sticky, white film of bacteria that forms on teeth, causing tooth decay, inflammation of the gums, periodontal disease and bad breath.

Prophylaxis/Cleaning: Cleaning, scaling and polishing procedure performed to remove plaque, tartar and stains from teeth above the gum line.

Periodontal Scaling/Deep Cleaning: The removal of plaque and tartar from the crowns and root surfaces above and under the gum in Members with periodontal disease. A routine prophylaxis/cleaning cannot be performed on a Member with untreated periodontal disease.

Resin "White" Filling: A plastic-like filling that is tooth colored and is used to fill cavities in teeth caused by decay. These fillings can be used on both front and back teeth enhancing a cosmetic effect.

Root Canal: Removal of the pulp inside a tooth and its roots due to infection or fracture.

Sealant: Protective plastic coating that covers grooves in healthy teeth to prevent decay. Sealants are usually applied to permanent back teeth.

Space Maintainer: An appliance inserted in the mouth to prevent drifting and crowding of teeth after removal of a baby tooth.

TYPES OF SPECIALISTS

Endodontist: Specializes in root canal therapy.

Oral Surgeon: Specializes in extractions and surgery.

Orthodontist: Specializes in adjustment of bite and braces.

Pedodontist: Specializes in the care of children.

Periodontist: Specializes in the care of gums.

Prosthodontist: Specializes in the replacement of missing teeth.