DENTAL COVERAGE

Summary Plan Description

Good dental habits are an important part of safeguarding your general health, and can also help you reduce dental bills. IQVIA dental coverage, provided by Delta Dental, is designed to encourage good preventive care to help you maintain healthy teeth and gums.

Under this coverage, you have two options available to you and your eligible dependents that cover various dental services. Both options are designed to encourage preventive care, such as regular checkups, and to correct minor dental problems before they become more serious and costly. Delta Dental offers you a broad range of services when treatment is needed.

For More Information

For details about eligibility for benefits, when you can change your coverage and how you pay for coverage, see the *Participating in the Health Care Plans* section. For information about your legal rights under ERISA, general information on claims review and appeal procedures and other important administrative details, see the *Administrative Information* section. To contact the plan administrator, use the information listed in the *Contacts* section.

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AT A GLANCE

Questions?

If you have questions about your dental benefits or need claim forms, call Delta Dental at 800-932-0783, or log on to their website at www.deltadentalins.com.

IQVIA offers two dental coverage options: The Standard Plan and The Enhanced Plan. You can see any dentist you want, whether they are in network or out of network. If you see a network dentist, you save money because network dentists discount their services and don't charge more than the discounted rate, so you never receive a "balance due" bill. Preventive care is covered at 100% in and out of the network but out-of-network charges may be subject to balance billing. Here is a quick look at what both plans cover. For more details about the type of covered services, see "Benefits Covered by the Dental Plan" on page 88.

Covered Services	Standard Plan	Enhanced Plan
Preventive (check-ups, cleanings, fluoride treatment, bitewing X-rays, sealants)	100% no deductible	
Annual Deductible for Basic and Major Services	$50 individual/$150 family	$50 individual/$150 family
Basic (fillings, root canal treatment, simple tooth extractions)	80% after deductible	
Major (crowns, bridges, dentures, implants)	50% after deductible	
Calendar Year Maximum for Basic and Major Services Combined	$1,500 per calendar year per person	$2,000 per calendar year per person
Orthodontia (braces and related treatment)	Not covered	$2,500 per person*)

* The plan will pay 50% of the benefit for orthodontia treatment at the time of the initial treatment and the remaining 50% 12 months later, assuming you continue to be enrolled in the Enhanced Dental Plan. The general plan of treatment for orthodontic care is 18 to 24 months. If the course of treatment is less than 12 months, the plan will make one payment at the time of the initial treatment.

Charges are paid in full up to the coinsurance amount in-network or at the coinsurance amount out-of-network up to the Program Allowance. This Program Allowance limit applies to preventive care as well as the other services listed.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

Can I carry over any dental expenses from one year to the next to meet my deductible?

No, expenses that apply toward your deductible in one calendar year can't be applied toward the next calendar year deductible.

What expenses are not applied to the deductible?

The following services do not apply toward the deductible:

- Services not covered by the plan.
- Expenses in-excess of Program Allowance charges.

Does the plan pay for treatment started before my coverage starts?

No. The plan doesn't pay for any treatment performed before you or your covered family members were covered by the plan.

I prepaid my entire orthodontia costs when I started treatment. How do I get this reimbursed to me from Delta Dental?

To receive benefits from the plan for covered orthodontia expenses, you will need to file a claim form with Delta Dental. The orthodontia benefit is administered in periodic payments. Claim forms are available at www.deltadentalins.com. See "Filing a Dental Claim" on page 90 for details.

HOW THE DENTAL PLAN WORKS

ID Cards

All dental plan participants will receive dental ID cards (two per family). Additional cards can be printed on www.deltadentalins.com or downloaded to your smartphone.

There are two levels of dental coverage:

- **The Standard Plan:** Offers coverage levels that may be appropriate if you have minimal dental expenses and wish to keep your monthly coverage contribution low. There is no coverage for orthodontia.
- **The Enhanced Plan:** Offers enhanced coverage that may be appropriate if you need more extensive dental services. The plan's maximums are higher. In addition, orthodontia is offered for adults and dependent children to age 26. There is no deductible for orthodontia services.

With both coverage options:

- You can use any dentist you choose.
- Delta Dental offers a network of dentists who have agreed to charge lower, fixed fees for services. You save money by using network dentists.
- Preventive care is covered at 100% at an in-network provider or 100% up to the Program Allowance at an out-of-network provider.
- You may have to file a claim form if you use an out-of-network provider. Claim forms are available at www.deltadentalins.com.
- To access your specific eligibility, benefits, and claims detail online, you will need to register at www.deltadentalins.com. On the homepage, go to Online Resources on the top right of the page. Click "Register Today," and follow the instructions. You will need your member ID on your Delta Dental ID card, or you can use your Social Security Number.

IN-NETWORK BENEFITS

If you choose to see a dentist in the PPO Provider or Premier Provider Network, your out-of-pocket expenses will usually be less. The plan will pay benefits for covered expenses based on negotiated, fixed fees.

To see if your dentist is in the network, log in to www.deltadentalins.com and use the Find a Dentist tool on the bottom right of the homepage.

If you need any assistance locating your dentist in the network, call Delta Dental at 800-932-0783.

OUT-OF-NETWORK BENEFITS

If you go to an out-of-network provider, the plan will pay benefits based on the Program Allowance. Because these providers are not a part of Delta Dental's network, your out-of-pocket expenses may be higher.

PAYING FOR YOUR CARE

Preventive care is covered at 100% at an in-network provider or 100% up to the Program Allowance at an out-of-network provider. For basic and major services, you must meet the annual deductible before you and IQVIA begins to share the cost of services. There is no annual deductible for orthodontia services in the Enhanced Plan.

DEDUCTIBLE

Deductible

The deductible is the amount you pay each year for eligible dental expenses before the plan begins to pay benefits.

The deductible is the amount of covered charges you pay each year for basic and major services combined before the plan begins paying benefits. In both plans, you pay a $50 per person deductible each year for individual coverage and $150 deductible for family coverage. With family coverage, the maximum deductible is $150.

Meeting the Deductible

The annual deductible applies to basic and major services combined – you don't have to meet a separate deductible for each type of service you receive.

For example, if you satisfy the individual deductible after paying for basic treatment, like a filling, no deductible would be required if you need major treatment, such as a crown, later in the year.

If you have selected family coverage, a combination of covered family members must meet the family annual deductible. Once the family deductible is met, no one person has to meet the individual deductible for the remainder of a given year.

COINSURANCE

Coinsurance

After you meet the deductible, you and IQVIA each pay for a percentage of the cost for covered services called coinsurance.

After you meet the deductible for basic and major services, you and IQVIA share a percentage of the cost each time you receive dental services. The coinsurance amount for basic and major services that the plan pays is the same for both plan options and is listed below for each type of service:

- Basic (e.g., filling, simple extractions, root canals, gum treatment): 80% after deductible
- Major (e.g., crowns, bridges, dentures, implants): 50% after deductible

In the Enhanced Plan, the plan will pay 50% of the benefit for orthodontia treatment at the time of the initial treatment and the remaining 50% 12 months later, assuming you continue to be enrolled in the Enhanced Dental Plan. The general plan of treatment for orthodontic care is 18 to 24 months. If the course of treatment is less than 12 months, the plan will make one payment at the time of the initial treatment.

CALENDAR YEAR MAXIMUM

The plan continues to pay a percentage of your covered basic and major services combined until the maximum annual benefit has been paid. Once you reach the maximum, the plan stops paying benefits for the rest of the plan year. Remember, if you use a Delta Dental network dentist, you pay discounted fees, so you can maximize your plan benefits by using in-network providers. Below are the benefit maximums for each plan option:

- Standard Plan: $1,500 per person per calendar year
- Enhanced Plan: $2,000 per person per calendar year

ORTHODONTIA LIFETIME MAXIMUM

In the Enhanced Plan, the plan will pay a percentage of your covered orthodontia services up to the lifetime maximum benefit of $2,500 per person. Then, the plan stops paying benefits. Remember, if you use a Delta Dental network dentist, you pay discounted fees, so you can maximize your plan benefits by using in-network providers.

OTHER PLAN FEATURES

Tip: Ask for a Pre-Treatment Estimate

Find out what the plan will pay before you receive treatment to ensure you get the best treatment at an affordable cost.

Pre-treatment Estimate for Benefits

Pre-treatment estimate requests are not required; however, your provider may file a claim form before beginning treatment, showing the services to be provided to you. Delta Dental will estimate the amount of benefits payable under the contract for the listed services. By asking your provider for an estimate from Delta Dental before you agree to receive any prescribed treatment, you will have an estimate up front of what Delta Dental will pay and the difference you will need to pay. The benefits will be processed according to the terms of the contract when the treatment is actually performed.

Suitable Plan of Treatment

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment. If you request or accept a more costly covered service, you are responsible for expenses that exceed the amount covered for the least costly service.

If You Are Out of Town

Delta Dental's network is national and available in all 50 states, Puerto Rico, and the District of Columbia. If you are out of town and need dental work, call Delta Dental at 800-932-0783 for a list of network dentists in the area or go to www.deltadentalins.com.

If You Need Emergency Dental Treatment

The plan pays the same amount for emergency service charges made by an in- or out-of-network provider. Dental emergency services are required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.

BENEFITS COVERED BY THE DENTAL PLAN

The list of services below are covered by the plan if the service is ordered or prescribed by a dentist, essential for the necessary care of teeth and is within the scope of coverage limitations. In addition, charges for these services will be paid only if the deductible is met (if applicable), the maximum benefit is not exceeded and the amount is not more than what is allowed under a suitable treatment plan.

Class I: Preventive and Diagnostic Services

- Oral exams: Two each calendar year.
- Emergency treatment for pain relief.
- X-rays:
  - Bitewing: Two of any bitewing X-ray procedures within a calendar year.
  - Full mouth (10 or more teeth at one time): One within a five (5)-year period.
  - Panoramic: One within a five (5)-year period.
- Cleanings (routine): Two each calendar year.
- Fluoride treatment: Once each calendar year (to age 19).
- Sealants: One per posterior tooth, without caries, within a five (5)-year period.
- Space maintainers (to age 19).
- Palliative (emergency) treatment.

Class II: Basic Restorative Services

- Amalgam fillings.
- Composite/resin fillings for all teeth.
- Root canal therapy.
- Periodontal scaling and cleaning root planing.
- Periodontal maintenance (cleaning): Two of any cleanings (routine or periodontal) each calendar year.
- Bridge recement (once per quadrant per lifetime).
- Extractions:
  - Simple extractions.
  - Endodontic treatment, including root canals.
  - Periodontic treatment or surgery to remove diseased gum tissue or bone.
- Anesthesia:
  - Local anesthetic, analgesic and routine postoperative care.
  - IV sedation.
- Pin retention.
- Therapeutic pulpotomy.
- Pulp caps: One per tooth (as medically necessary).
- Apiceotomy.

Class III: Major Restorative Services

- Osseous surgery.
- Extractions: Impacted teeth.
- Crowns and inlays:
  - Crown build-ups and lengthening.
  - Restorations covered only as a result of extensive caries or fracture and cannot be replaced with amalgam, silicate, acrylic or plastic restoration.
  - Crown and inlay recement (once per tooth per lifetime).
- Onlays.
- Dentures (full and partial), including adjustments during the six-month period following installation and relining once per arch every three (3) calendar years and more than six months from the date of insertion.
- Bridges (fixed or removable).
- Prosthesis (replacement covered only if the existing prosthesis is at least five years old).
- General anesthesia (only if performed as part of a covered surgical procedure).

Class IV: Orthodontia

- Cephalometric X-rays.
- Diagnostic casts.
- Active and retention appliances.
- Active treatment.

The plan will pay 50% of the benefit for orthodontia treatment at the time of the initial treatment and the remaining 50% 12 months later, assuming you continue to be enrolled in the Enhanced Dental Plan. The general plan of treatment for orthodontic care is 18 to 24 months. If the course of treatment is less than 12 months, the plan will make one payment at the time of the initial treatment.

BENEFITS NOT COVERED BY THE DENTAL PLAN

The following expenses are not covered under the Dental Plan:

- Bite registrations; precision or semi-precision attachments; splinting.
- Charges above the Program Allowance.
- Charges made by a hospital performing services for the U.S. Government for a condition connected to military service.
- Charges that would not have been made if you had no insurance.
- Charges you are not legally required to pay.

- Cosmetic dentistry.
- Dental services that do not meet common dental standards.
- Charges covered under an auto insurance policy in compliance with the "no-fault" or uninsured motorist law. Delta Dental will take into account any adjustment option you or any of your dependents choose.
- Charges that are paid or are eligible for payment through a public program, other than Medicaid.
- Charges that are unlawful where you reside when the expenses are incurred.
- Experimental or investigational procedures and treatments.
- Injury resulting from, or in the course of, any employment for wage or profit.
- Instruction for plaque control, oral hygiene and diet.
- Medical services.
- Prescription drugs.
- Procedures, appliances or restorations, other than full dentures, that:
  - Change vertical dimension.
  - Diagnose or treat conditions of TMJ.
  - Stabilize periodontally involved teeth.
  - Restore occlusion.
- Procedures performed by a dentist who is a member of the covered person's family (e.g., spouse, siblings, parents, children, grandparents and the spouse's siblings and parents).
- Replacement of a bridge or denture within five years of installation or if it still meets the dental standards of functional acceptability.
- Replacement of a lost or stolen appliance.
- Services and supplies received from a hospital.
- Sickness covered under any Workers' Compensation or similar law.
- Unnecessary care, treatment or surgery.

In addition, your benefits will be reduced so that the total payment will not be more than 100% of the charge made for a dental service, if benefits are provided for that service under this plan and the IQVIA Medical Plan.

If You Have a Spending Account

If you sign up for a Health Savings Account, Combination Health Care Flexible Spending Account or Health Care Flexible Spending Account, you may submit eligible out-of-pocket expenses or eligible expenses that are not covered by the Dental Plan.

FILING A DENTAL CLAIM

To receive benefits from the plan for covered dental expenses from an out-of-network provider, you may need to file a claim form with Delta Dental. Separate claim forms must be submitted for each person filing a claim. Claim forms are available at www.deltadentalins.com.

To download a claim form, click "Enrollees," then "Managing Costs", and then "How to file a Dental Claim", and then "Delta Dental PPO, DPO and Delta Dental Premier."

Complete claim forms and itemized bills should be sent to the address noted on the claim form.

Before you or your provider submits your claim form, make sure you include your member ID and account number located on your benefits ID card.

APPEALING CLAIMS

If a claim for reimbursement under the Dental Plan is denied, either in whole or in part, you can appeal the denial by following the appropriate procedures described in the *Administrative Information* section.