

Dental Plans

There are two dental plans to choose from—the Metropolitan Life Insurance Plan (MetLife) and the Delta Dental Plan of Ohio (Delta Dental). You may elect either plan, but not both.

The dental plans pay benefits to you and your covered dependents for a wide range of dental services and supplies, including preventive, diagnostic, restorative, prosthodontic and orthodontic care.

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Your Dental Plans ...

... Encourage Preventive Care

The dental plans promote regular dental care by covering preventive and diagnostic services, such as routine checkups, cleanings and X-rays, at 100% of Reasonable and Customary Charges with no deductible.

... Offer Protection for More Extensive Treatment

Oral surgery and restorative and prosthodontic services are covered after you meet the annual deductible.

... Provide Orthodontic Benefits for Your Children

Coverage for orthodontic treatment is available for your Eligible Dependent Children under age 26.

What happens to your benefits when ...

For more information about what happens to your dental benefits when certain changes or events occur, see "How Changes Affect Your Benefits" in the "About Your Benefits" section.

For more information about coverage you and your Eligible Dependents may be eligible to continue in certain cases when coverage would otherwise end, refer to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) within the "Administrative Information" section.

Some facts to remember about your dental plans ...

- **Dependents in military service are not eligible for dental coverage.**
- **These plans cover services outside the United States.**
- **Dental coverage may not be converted to individual coverage.**
- **This information is a summary of the dental benefits under the plans. Should there be a conflict between the summary and the group contract, the group contract will control.**
- **A predetermination of benefits is recommended for costs that are expected to exceed \$100.**

Administrative Information

Information about the administration of your dental plans can be found in the section entitled "Administrative Information."

MetLife Dental Plan

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How the MetLife Dental Plan Works

You select and schedule an appointment with the provider of your choice. You are not required to use a network provider. There is a difference in how a network provider and a non-network provider bills for their services.

Network Provider

MetLife has a Preferred Dentist Program (PDP) network. Participating dentists agree to accept a discounted fee schedule as full payment for covered service. You will not be billed for any covered charges that are greater than the contracted fee schedule if you use a PDP provider.

Non-Network Provider

The Plan pays benefits to non-network providers based on “Reasonable and Customary Charges.”

If you use a provider that is not part of the contracted PDP network, the plan pays benefits toward covered dental expenses on the basis of “Reasonable and Customary Charges.”

If you incur charges that exceed what is considered Reasonable and Customary, the plan covers the Reasonable and Customary Charge and you are responsible for paying the balance. Charges beyond Reasonable and Customary will not count toward the deductible.

Briefly, the plan covers four types of dental services:

- Type A – Preventive and diagnostic services
- Type B – Oral surgery and restorative services
- Type C – Prosthodontic services
- Type D – Orthodontic services.

The plan pays different benefits for each of these types of coverage – with one annual deductible required for Type B and Type C services only.

Annual Deductible

You and each covered dependent must satisfy a \$50 individual deductible each calendar year before benefits become payable toward Type B (oral surgery and restorative) services and Type C (prosthodontic) services covered by the plan. The deductible does not apply to Type A (preventive and diagnostic) or Type D (orthodontic) services.

Maximum Benefits

The plan pays up to a maximum of \$1,500 per year and \$20,000 in a lifetime for each covered person for Type A, Type B, and Type C expenses combined. For Type D (orthodontic) services, there is a separate lifetime maximum of \$1,500 in benefits for each covered person.

Four Types of Dental Services

- Type A:** Preventive and diagnostic services
- Type B:** Oral surgery and restorative services
- Type C:** Prosthodontic services
- Type D:** Orthodontic services

MetLife Dental Plan—Summary of Benefits

MetLife Dental Plan

Refer to the "Covered Expenses" section, provided on the following page, for details.

Services Covered	Amount of Coverage Per Member*
Calendar Year Maximum	\$1,500
Lifetime Orthodontic Maximum	\$1,500
Lifetime Maximum	\$20,000
Annual Deductible (applies to Type B and Type C services)	\$50 per member
Services Covered	Amount of Coverage Per Member*
TYPE A – Preventive and Diagnostic Services:	
• Oral Examinations	Covered 100%, once every 6 months
• Prophylaxis (cleanings)	Covered 100%, once every 6 months
• Full mouth X-rays	Covered 100%, once every 24 months
• Bite-wing X-rays	Covered 100%, one set every 6 months
• Fluoride	Covered 100%, once every 6 months, under age 19
• Space Maintainers	Covered 100%
TYPE B – Oral and Restorative Services:	
• Fillings (other than gold), general anesthesia, occlusal guards, extractions and oral surgery*, periodontics, endodontics (root canal therapy)	Covered 80% after deductible
• Sealants	Not covered
TYPE C – Prosthodontic Services	Covered 50% after deductible
• Crowns	No age limit
• Bridges	No age limit
• Partial/Full Dentures	No age limit
• Inlays/Onlays	No age limit
• Implants	Not covered
TYPE D – Orthodontic Services: braces, surgical repositioning to correct malocclusion, surgical extractions, X-rays, retention checking	Scheduled benefit for dependents up to age 26, up to the lifetime orthodontic maximum \$300 initial payment and \$49.50 for each month following (paid quarterly) up to the lifetime orthodontic maximum
<p>*Reasonable and Customary Charges apply for non-network providers. The PDP network fee schedule applies for PDP providers.</p> <p>*Oral surgery may be covered under the medical plan</p>	

MetLife Dental Plan—Covered Expenses

Type A—Preventive and Diagnostic Services

The dental plan pays 100% of covered expenses for Type A (preventive and diagnostic) services, with no deductible required.

Covered expenses for preventive and diagnostic services include Reasonable and Customary Charges for:

- oral examinations (once every 6 months)
- cleaning and scaling of teeth (once every 6 months)
- bitewing X-rays (one set every 6 months)
- full mouth X-rays (one set every 24 months)
- topical fluoride applications for Children under age 19 (once every 6 months)
- space maintainers
- emergency treatment.

Type B—Oral Surgery and Restorative Services

After the deductible has been satisfied, the plan pays 80% of covered expenses for Type B (oral surgery and restorative) services.

Covered expenses for oral surgery and restorative services include Reasonable and Customary Charges for:

- amalgam fillings (charges for precious metals such as gold and for castings are considered based on Reasonable and Customary Charges for amalgam fillings)
- treatment of gum disease (periodontics)
- endodontic treatment, including root canal services
- extractions (except in connection with orthodontic treatment)
- oral surgery
- general anesthesia when determined necessary under the plan's dental provisions.
- repair or re-cementing of crowns, inlays, onlays, dentures, or bridgework

Type C—Prosthodontic Services

After the deductible has been satisfied, the plan pays 50% of covered expenses for Type C (prosthodontic) services.

Covered expenses for prosthodontic services include Reasonable and Customary Charges for:

- inlays, onlays, crowns, and gold fillings
- fixed bridgework installed for the first time to replace missing natural teeth, including inlays and crowns as abutments, but excluding periodontal splinting, once in 60 months
- full or partial dentures installed for the first time to replace missing natural teeth and adjacent structures and any adjustments required during the 6 month period following installation, once in 60 months
- replacement or modifications of dentures or bridgework if required:
 - to replace one or more teeth extracted after the existing denture or bridgework was installed
 - to replace an existing appliance which is at least 60 months old and cannot be made serviceable
 - to replace a temporary denture that cannot be made permanent and has been in place 12 months or less.

Type D—Orthodontic Services

No deductible applies to Type D covered expenses.

All covered Children through age 25 are eligible to receive benefits for orthodontic services. At age 26, all coverage under the plan ends, even if a course of orthodontic treatment is ongoing.

The plan payment for covered expenses (initial and monthly) is based on a schedule. This schedule is available from the ORNL Benefits Office.

Covered expenses for orthodontic services include charges for:

- braces
- surgical repositioning of the jaw, facial bones, and/or teeth to correct malocclusion
- surgical extractions
- X-rays
- retention checking.

MetLife Dental Plan—Exclusions

The MetLife Dental plan does not cover certain expenses, including but not limited to charges for:

- services provided before plan coverage becomes effective
- services other than those specifically covered by the plan
- services and supplies that are not provided by a legally licensed dentist or physician (or a licensed hygienist for the scaling or cleaning of teeth and topical application of fluoride under the dentist's supervision)
- services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures
- replacement of a lost, missing, or stolen prosthetic device
- services covered by any Workers' Compensation laws or employer's liability laws, or services which an employer is required by law to furnish in whole or in part
- services rendered through a medical department, clinic, or similar facility provided or maintained by the patient's employer
- services or supplies for which a covered person would not legally have to pay if there were no coverage
- services or supplies which do not meet accepted standards of dental practices, including charges for services or supplies which are unnecessary or experimental in nature
- services or supplies received as a result of dental disease, defect, or injury due to an act of war, whether declared or not
- dental services or supplies that are payable by any government
- any duplicate prosthetic devices or sealants (material, other than fluorides, painted on the grooves of the teeth in an attempt to prevent future decay), oral hygiene, and dietary instruction
- plaque control programs
- implantology (an insert set firmly or deeply into or onto the part of the bone that surrounds and supports the teeth)
- periodontal splinting
- myofunctional therapy.

Expenses incurred for any of the services or supplies listed above may not be used to satisfy your deductible.

MetLife Dental Plan

Extended Dental Care Benefits

If your coverage ends because your employment terminates, you retire, or you lose eligibility, benefits for covered expenses incurred before your termination remain payable under the plan.

If you are undergoing a course of treatment when your coverage ends, benefits are payable for most covered charges related to that treatment and incurred up to 30 days after your termination.

Exceptions to this 30 day extension include treatment involving:

- **prosthetic devices** – impressions and tooth preparation must be completed before coverage ends and the device must be installed or delivered within 2 calendar months following the end of coverage
- **crowns** – tooth preparation must be completed before the coverage ends and the crowns installed within 2 calendar months following the end of coverage
- **root canal therapy** – the tooth must be opened before coverage ends and treatment completed within 2 calendar months following the end of coverage
- **orthodontia** – not extended, under any circumstance.

Predetermination of Benefits

When you or your covered Eligible Dependents require dental care and treatment, you should discuss in advance with your dentist what needs to be done and how much it will cost. If treatment is expected to cost \$100 or more, you should ask your dentist to file for predetermination of benefits. This helps you avoid surprises by letting you know how much is payable for the proposed treatment before it begins.

Here is how it works:

- Your dentist submits the proposed course of treatment to MetLife by itemizing services and charges on a regular claim form.

- MetLife then determines the amount the plan will pay and informs you and your dentist by sending each of you a "Notice of Benefits Allowable" statement.
- You are free to pursue any treatment; however, the plan may only pay for the treatment that is indicated on the "Notice of Benefits Allowable."

Whether or not you request predetermination of benefits, MetLife will pay the claim based on whatever information it has about your treatment.

MetLife Dental Plan (cont'd.)

Alternative Course of Treatment

If, according to generally accepted professional standards of dental practice, there is more than one suitable procedure for the treatment of a dental condition, the plan will pay benefits for the least expensive procedure that can be used for the effective treatment of that condition. MetLife determines the benefit reimbursement amount when alternative courses of treatment are available.

If you and your dentist elect to use a more expensive procedure or material than the one determined to be appropriate by MetLife, you will be required to pay the difference between the dentist's bill and the costs covered by the plan.

Treatment in Progress

The plan does not cover treatment received before your insurance becomes effective. However, if a course of treatment is started before the effective date and completed after the effective date, part of

the cost may be covered. MetLife will determine whether a portion of the dentist's fee can be allocated to treatment received after the effective date and covered under the plan.

Claiming Benefits

Your dentist will usually file a claim whenever you and your covered Eligible Dependents incur covered dental expenses. Claims must be filed no later than 90 days after the plan year in which the services were rendered.

If you should need to file a claim, you may obtain a claim form from the ORNL Benefits Service Center website. Completed forms should be mailed to MetLife at the address listed on the form.

MetLife will send an explanation of payment with the benefit check. If you have authorized MetLife to pay your dentist directly, the dentist will receive an explanation of payment with the check, and you will receive a copy of the explanation if your claim was not paid in full.

MetLife Dental Plan (cont'd.)

Coordination of Benefits

The dental plan has a Coordination of Benefits (COB) provision that is designed to prevent duplication of payments when a person can collect benefits from more than one employer group dental plan.

Under this provision, when coverage is provided both by the Company and another employer group plan, you can receive up to 100% of your covered expenses from both plans, but no more than that.

Other Company Benefits

If you have an accidental injury, seek recommended care through your medical plan's primary care physician to receive in-network benefits. Treatment of injuries to your natural teeth by a dentist, physician, or surgeon is covered under your medical coverage as long as services are provided within 12 months of the accident.

File your medical claim with your medical plan. A claim must be filed no later than 90 days after the plan year in which services were rendered.

Dental benefits payable under a Company medical plan will reduce your benefits otherwise payable under the dental plan. After you receive notice of payment from the medical plan, you should submit the notice of payment to MetLife.

Delta Dental Plan

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How the Delta Dental Plan Works

Eligibility and Enrollment

The general eligibility and enrollment provisions can be found in the section entitled "About Your Benefits."

A subscriber or dependent who drops their coverage, but who still meets all eligibility requirements of the plan, may re-enroll during the first Open Enrollment period after having been out of the plan for 12 consecutive months.

For further definitions of Eligible Employees, Eligible Dependents, and the term Child(ren), refer to the "Glossary" and "About Your Benefits" sections.

Choosing a Dentist

Delta Dental has contracted with "Participating Dentists" in two networks: Delta Dental PPO and Delta Dental Premier. These dentists are independent contractors who have agreed to accept certain fees for the services they provide to you. Dentists who have not contracted with Delta Dental are referred to as "Nonparticipating Dentists."

Although you are free to choose any dentist, your out-of-pocket expenses are likely to be lowest if you choose a dentist in the Delta Dental PPO network. This is because PPO dentists have agreed to accept fees that are typically lower than those that Delta Dental Premier or nonparticipating dentists will accept. But if you don't choose a Delta Dental PPO dentist, you can still save money if you go to a dentist who participates in Delta Dental Premier. Therefore, before receiving dental treatment, you should always verify if your dentist participates in one of these networks by calling the dentist's office, calling Delta Dental's Customer Service department at (800) 524-0149, or checking the online dentist directories at www.deltadentaloh.com

Participating vs Nonparticipating

PPO Dentists are paid based on Delta Dental's PPO fee schedule, and Premier dentists are paid based on Delta Dental's maximum approved fees. Participating providers agree to accept these fees, with no balance billing, as payment in full. You will only be responsible for any applicable copayments and deductibles. If you go to a Nonparticipating Dentist, you will be responsible for the difference between Delta Dental's payment and the amount that the Nonparticipating Dentist charges, in addition to your copayment and deductible. The Nonparticipating Dentist may require that you pay the full amount up front, and you may

have to fill out and file your own claim forms. Delta Dental will send reimbursement to you, and you will be responsible for making full payment to the Nonparticipating Dentist.

PPO fee schedule amounts and maximum approved fees are based on fees charged in your geographic area.

Annual Deductible

You and each covered dependent must satisfy a \$50 individual deductible each calendar year before benefits become payable toward Class II (basic) services and Class III (major) services covered by the plan. There is no deductible for Class I (diagnostic and preventive) services or Class IV (orthodontic) services.

Maximum Benefits

The plan pays up to a maximum of \$1,500 per year for each covered person for all services except cephalometric film, photos, diagnostic casts, and orthodontics. For cephalometric film, photos, diagnostic casts and orthodontics, there is a separate lifetime maximum of \$1,500 for each covered person.

Emergency Dental Care

If you require emergency dental care, you may seek services from any dentist. Your out-of-pocket expenses will likely be less if you choose a Participating Dentist.

Four Classes of Dental Services

- Class I:** Diagnostic and Preventive Services
- Class II:** Basic Services
- Class III:** Major Services
- Class IV:** Orthodontic Services

The Delta Dental plan pays different benefits for each of these types of coverage, with an annual deductible required for Class II and Class III services only.

Delta Dental Plan—Summary of Benefits

Refer to the "Exclusions and Limitations" section, provided on the following pages, for details.

Services Covered	Amount of Coverage Per Member
Calendar Year Maximum (excludes cephalometric film, photos, diagnostic casts, and orthodontics)	\$1,500
Lifetime Maximum (only applies to cephalometric film, photos, diagnostic casts, and orthodontics)	\$1,500
Annual Deductible (applies to Class II and Class III services only)	\$50
Services Covered	Amount of Coverage Per Member
CLASS I—Diagnostic and Preventive Services:	
<ul style="list-style-type: none"> Oral Examinations 	Covered 100%, twice every 12 months
<ul style="list-style-type: none"> Prophylaxes (cleanings) 	Covered 100%, twice every 12 months
<ul style="list-style-type: none"> Full mouth X-rays 	Covered 100%, once every 3 years
<ul style="list-style-type: none"> Bitewing X-rays 	Covered 100%, twice every 12 months
<ul style="list-style-type: none"> Fluoride 	Covered 100%, twice every 12 months, under age 19
<ul style="list-style-type: none"> Space Maintainers 	Covered 100% under age 14
CLASS II—Basic Services:	
<ul style="list-style-type: none"> Emergency palliative treatment, fillings, periodontics, endodontics (root canal therapy), and oral surgery 	Covered 80% after deductible (See Dental Certificate for all exclusions and limitations)
<ul style="list-style-type: none"> Sealants 	Covered 80% after deductible, under age 16, once per tooth per lifetime. Chewing surfaces for permanent first and second molars only. The surface must be free from decay and restorations.
CLASS III—Major Services:	
<ul style="list-style-type: none"> Crowns 	Covered 50% after deductible (porcelain crowns on posterior teeth are optional treatment—see exclusions and limitations)
<ul style="list-style-type: none"> Implants 	Covered 50% after deductible, once per tooth every 5 years
<ul style="list-style-type: none"> Bridges 	Covered 50% after deductible (See Dental Certificate for all exclusions and limitations)
<ul style="list-style-type: none"> Partial Dentures/Full Dentures 	Covered 50% after deductible (See Dental Certificate for all exclusions and limitations)
<ul style="list-style-type: none"> CLASS IV—Orthodontic Services: (services, treatment and procedures to correct malposed teeth, including braces) 	Covered 50% for dependents up to age 26, up to the lifetime orthodontic maximum

Delta Dental Schedule of Benefits

Class I—Preventive and Diagnostic Services

Preventive—prophylaxis (cleaning), topical application of fluoride, and space maintainers.

Diagnostic—oral examination and X-rays to aid the dentist in planning required dental treatment.

Class II—Basic Benefits

Oral Surgery—extractions and other surgical procedures (including pre- and post-operative care).

General Anesthesia and Intravenous Sedation—only when administered by a properly licensed dentist in a dental office in conjunction with covered surgery procedures or when necessary due to concurrent medical conditions.

Endodontia—treatment of the dental pulp (root canal procedures).

Periodontia—treatment of the gums and bones that surround the tooth.

Denture Repairs—services to repair complete or partial dentures.

Basic Restorations—amalgams (silver fillings) composites (white fillings) and prefabricated stainless steel crown restorations for the treatment of decay.

Sealants—resin filling used to seal grooves and pits on the chewing surface of permanent molar teeth.

Occlusal guards.

Class III—Major Benefits

Cast Restorations—Crowns and onlays are benefits for the treatment of visible decay and fractures of hard tooth structure when teeth are so badly damaged that they cannot be restored with amalgam or composite restorations.

Prosthodontics—Procedures for construction of fixed bridges, partial or complete dentures and repair of fixed bridges.

Complete or Partial Denture Reline—Chair-side or laboratory procedure to improve the fit of the appliance to the tissue (gums).

Complete or Partial Denture Rebase—Laboratory replacement of the acrylic base of the appliance.

Class IV—Orthodontic Services

Delta Dental will pay benefits for procedures using appliances to treat poor alignment of teeth and/or jaws. Such poor alignment must significantly interfere with function to be a benefit.

Delta Dental Exclusions and Limitations

Exclusions

Delta Dental will make no payment for the following services unless otherwise specified in the Summary of Dental Plan Benefits. All charges for the following services will be the responsibility of the Subscriber (though the Subscriber's payment obligation may be satisfied by insurance or some other arrangement for which the Subscriber is eligible). This is a partial listing; please see your Dental Care Certificate for all exclusions and limitations

Limitations and Exclusions on Preventive and Diagnostic Benefits

Two oral exams and cleanings, to include periodontal maintenance procedures in any 12 month period.

Members with certain high-risk medical conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.

Full mouth X-rays are covered once within 3 years, unless special need is shown.

Two sets of bite-wing X-rays in a 12 month period.

Topical application of fluoride for members up to 19 years of age.

Adult prophylaxis for members under 14 years of age is not allowed.

Space maintainers for members age 14 and older are not allowed.

Limitations and Exclusions on Basic Benefits

Restorative benefits are allowed once per surface in a 24 month period, regardless of the number or combinations of procedures requested or performed.

Payment for root canal treatment includes charges for X-rays and temporary restorations. Root canal treatment is limited to once in a 24 month period by the same dentist or dental office.

Payment for periodontal surgery shall include charges for 3 months postoperative care and any surgical re-entry for a 3 year period. Root planing, curettage and osseous surgery are not a benefit for members under 14 years of age.

The replacement, by the same dentist or dental office, of amalgam or composite restorations within 24 months is not a benefit.

The replacement of a stainless steel crown on a primary tooth by the same dentist or dental office within a 24-month period of the initial placement is not a benefit.

The replacement of a stainless steel crown on a permanent tooth by the same dentist or dental office within a 60 month period of the initial placement is not a benefit.

Gold foil restorations are an Optional Service.

Porcelain, composite, and metal inlays are Optional Services.

A sealant is a benefit only on the unrestored, decay-free chewing surface of the maxillary (upper) and mandibular (lower) permanent first and second molars. Sealants are only a benefit on members under 16 years of age. Only one benefit will be allowed for each tooth within a lifetime.

Limitations and Exclusions on Major Benefits

Replacement of crowns or cast restorations received in the previous 5 years is not a benefit. Payment for cast restorations shall include charges for preparations of tooth and gingiva, crown build-up, impression, temporary restoration and any re-cementation by the same dentist within a 12 month period.

A cast restoration on a tooth that can be restored with an amalgam or composite restoration is not a benefit.

Procedures for purely cosmetic reasons are not benefits.

Porcelain, gold or, veneer crowns for Children under 12 years of age are not a benefit.

Replacement of any fixed bridges, or partial or complete dentures, that the member received in the previous 5 years is not a benefit.

Payment for a complete or partial denture shall include charges for any necessary adjustment within a 6 month period. Payment for a reline or rebase of a partial or complete denture is limited to once in a 3 year period and includes all adjustments required for 6 months after delivery.

Payment for standard dentures is limited to the maximum allowable fee for a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth. A standard denture is made by conventional means from acceptable materials. If a denture is constructed by specialized techniques and the fee is higher than the fee allowable for a standard denture, the patient is responsible for the difference.

Payment for fixed bridges or cast partials for Children under 16 years of age is not a benefit.

A posterior bridge where a partial denture is constructed in the same arch is not a covered benefit.

Temporary partial dentures are a benefit only when upper anterior teeth are missing.

Delta Dental Exclusions and Limitations (cont'd.)

Limitations and Exclusions on Orthodontic Benefits

Orthodontic benefits are limited to Eligible Dependent Children to age 26.

Delta Dental shall make regular payments for orthodontic benefits.

If orthodontic treatment began prior to enrolling in this plan, Delta Dental will begin benefits with the first payment due the orthodontist after the subscriber or covered Eligible Dependent becomes eligible.

Benefits end with the next payment due the dentist after loss of eligibility or immediately if treatment stops.

Benefits are not paid to repair or replace any orthodontic appliance received.

Orthodontic benefits do not pay for extractions or other surgical procedures. However, these additional services may be covered under Preventive and Diagnostic or Basic Benefits.

Orthodontic Payment Method

The initial payment (initial banding fee) made by Delta Dental for comprehensive treatment will be 33% of the total fee for treatment subject to your copayment percentage and lifetime maximum.

Subsequent payments will be issued on a regular basis for continuing active orthodontic treatment. Payments will begin in the month following the appliance placement date and are subject to your copayment and lifetime maximum.

Delta Dental Plan

Predetermination of Benefits

When a proposed treatment plan will cost more than \$200, it is recommended that the dentist submit it to Delta Dental for predetermination. You may have your dentist send Delta Dental a claim form detailing the projected treatment, and Delta Dental will give an estimate of the benefits to be paid. This will let you know approximately how much the work will cost and what your share of the costs will be. A predetermination is not a guarantee of payment.

Actual benefit payments will be based upon procedures completed and will be subject to continued eligibility along with plan limitations and maximums. It is important to note that Delta Dental never dictates treatment—only payment. Delta Dental's payment can be applied toward the treatment the dentist and patient choose.

Optional Services

If you select a more expensive service than is customarily provided or for which Delta Dental does not determine a valid dental need is shown, Delta Dental will make an allowance based on the fee for the customarily provided service.

For example, if a posterior tooth can be satisfactorily restored with an amalgam (silver) restoration and you choose to have the tooth restored with a more costly procedure, such as a composite resin (white) restoration, the Plan will pay only the amount that it

would have paid to restore the tooth with amalgam. You are responsible for the difference in cost.

This determination is not intended to reflect negatively on the dentist's treatment plan or to recommend which treatment should be provided. It is a determination of benefits under the terms of the subscriber's coverage. The dentist and subscriber or dependent should decide the course of treatment.

Delta Dental Plan (cont'd.)

General Provisions

This is a partial listing; please see your Dental Care Certificate for all exclusions and limitations

- A. **Claims:** Participating Dentists (PPO and Premier) will file your claim with Delta Dental. If you need a claim form for services provided by a Nonparticipating Dentist, you can print one from Delta Dental's website at www.deltadentalmi.com. Delta Dental will make no payment for services if a claim for those services has not been received by Delta Dental within 1 year following the date the services were completed.
- B. **Emergency Dental Care:** If you require emergency dental care, you may seek services from any dentist. Your out-of-pocket expenses will likely be less if you choose a Participating Dentist (PPO or Premier).
- C. **Subrogation and Right of Reimbursement:** This provision applies when Delta Dental pays benefits for personal injuries and you have a right to recover damages from another.
- D. **Reimbursement:** If you or your Eligible Dependent recovers damages from any party or through any coverage named above, you must reimburse Delta Dental from that recovery to the extent of payments made under the Plan.
- E. **Actions:** No action on a legal claim arising out of or related to this Plan will be brought until the claims review and appeal process has been exhausted and 30 days after notice of the legal claim has been given to Delta Dental. A summary of the Claims Review and Appeal Procedures can be found in the section entitled "Administrative Information." In addition, no action can be brought more than 3 years after the legal claim first arose. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim.
- F. **Coordination of Benefits:** Coordination of Benefits (COB) is used to pay health care expenses when you are covered by more than one plan. Delta Dental follows rules established by Ohio law to decide which plan pays first and how much the other plan must pay. The objective of coordination of benefits is to make sure the combined payments of the plans are no more than your actual bills.

Which Plan is Primary?

To decide which plan is primary, Delta Dental will consider both the coordination provisions of the other plan and which member of your family is involved in a claim. The primary plan will be determined by the first of the following rules that applies:

1. **Employee**
The plan that covers you as an employee (neither laid off nor retired) is always primary.
2. **Children (Parents Divorced or Separated)**
If a court decree makes one parent responsible for health care expenses, that parent's plan is primary.

If a court decree gives joint custody and does not mention health care, Delta Dental follows the birthday rule.

If neither of those rules applies, the order will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.
3. **Children and the Birthday Rule**
When your Children's health care expenses are involved, Delta Dental follows the "birthday rule." Under this rule, the plan of the parent with the first birthday in a calendar year is always primary for the Children. If your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your Children. However, if your spouse's plan has some other coordination rule (for example, a "gender rule" that says the father's plan is always primary), Delta Dental will follow the rules of that plan.
4. **Other Situations**
For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

Delta Dental Plan (cont'd.)

General Provisions (cont'd.)

Coordination Disputes

If you believe that Delta Dental has not paid a claim properly, you should first attempt to resolve the problem by contacting Delta Dental. If you are still not satisfied, you may call the Ohio Department of Insurance at (614) 644-2673 or (800) 686-1526 for instructions on filing a consumer complaint.

- G. Claims Appeal Procedure: Delta Dental will notify you or your authorized representative if you receive an adverse benefit determination after your claim is filed. A summary of the Claims Review and Appeal Procedures can be found in the section entitled "Administrative Information."
- H. To request a formal appeal of your claim, you must send your request in writing to:

Dental Director
Delta Dental
P.O. Box 30416
Lansing, Michigan 48909-7916

You must include your name and address, the Subscriber's Member ID number, the reason you believe your claim was wrongly denied, and any other information you believe supports your claim, and indicate in your letter that you are requesting a formal appeal of your claim. You also have the right to review the Plan and any documents related to it. If you would like a record of your request and proof that it was received by Delta Dental, you should mail it certified mail, return receipt requested.

If you are still not satisfied, you may contact the Ohio Department of Insurance for instructions on filing a consumer complaint by calling (614) 644-2673 or (800) 686-1526. You may also write to the Consumer Services Division of the Ohio Department of Insurance, 50 W. Town St., Third Floor, Suite 300, Columbus, Ohio, 43215.

Delta Dental Plan (cont'd.)

Extended Dental Care Benefits

Coverage for any subscriber or Eligible Dependent terminates when they are no longer eligible for benefits as a member of the group.

Specific state or federal laws or group policies may allow an extension of benefits for a limited time.