

Dental Plans

For Under Age 65 Retiree and Spouse ...
There are two Dental Plans to choose from—the Metropolitan Life 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 under age 65 for a wide range of dental services and supplies, including preventive, diagnostic, restorative, prosthodontic, and orthodontic care.

For Over Age 65 Retiree and Spouse...
The Company does not offer a Dental Plan for retirees and spouses over age 65.

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Some Facts to Remember About your Dental Plans ...

- Dependents in military service are not eligible for dental coverage.
- 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.

What Happens to your Benefits When ...

For more information about eligibility and what happens to your dental benefits when certain changes or events occur, see the “About Your Benefits” chapter.

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 COBRA in the “Administrative Information” chapter.

MetLife Dental Plan

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MetLife Dental Plan

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 versus a non-network provider bills for 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

If you use a provider that is not part of the contracted PDP network, the plan pays benefits toward covered dental expenses based on “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 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.

MetLife Dental Plan

Summary of Benefits

Refer to the “Covered Expenses” section on the following page for details.

Services Covered	Amount of Coverage*
Calendar Year Maximum	\$1,500
Lifetime Orthodontic Maximum	\$1,500
Lifetime Maximum	NA
Annual Deductible (applies to Type B and Type C services)	\$50 per member
Services Covered	Amount of Coverage*
TYPE A—Preventive and Diagnostic Services	Covered 100%
<ul style="list-style-type: none"> • Oral Examinations 	Once every 6 months
<ul style="list-style-type: none"> • Prophylaxis (cleanings) 	Once every 6 months
<ul style="list-style-type: none"> • Periodontal Maintenance 	If approved, treatment is covered in addition to routine oral exams
<ul style="list-style-type: none"> • Full Mouth X-rays 	Once every 24 months
<ul style="list-style-type: none"> • Bite-wing X-rays 	One set every 6 months
<ul style="list-style-type: none"> • Fluoride 	Under age 19, once every 6 months
<ul style="list-style-type: none"> • Space Maintainers 	No age limit
TYPE B—Oral Surgery and Restorative Services	Covered 80% after deductible
<ul style="list-style-type: none"> • Restorative (fillings) • General anesthesia • Occlusal guards (TMJ appliances are excluded) • Extractions • Oral surgery (extractions and dental surgery) • Periodontics • Endodontics (root canal therapy) 	
<ul style="list-style-type: none"> • Sealants 	Covered 80% after deductible; under age 16; chewing surfaces for permanent first and second molars only—one benefit per tooth
TYPE C—Prosthodontic Services	Covered 50% after deductible
<ul style="list-style-type: none"> • Crowns, Inlays, and Onlays • Bridges, Partial Dentures, and Full Dentures 	Covered once every 60 months, no age limit
<ul style="list-style-type: none"> • Implants 	Covered once every 60 months per tooth

MetLife Dental Plan

Summary of Benefits (cont.)

Refer to the “Covered Expenses” section on the following page for details.

Services Covered	Amount of Coverage*
TYPE D—Orthodontic Services for dependents up to age 26: <ul style="list-style-type: none"> • Braces, surgical repositioning to correct malocclusion, surgical extractions, x-rays, retention checking 	\$300 initial payment and \$49.50 for each month following (paid quarterly) up to the lifetime orthodontic maximum
*Reasonable and customary charges apply for non-network providers. The PDP network fee schedule applies for PDP providers.	

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)
- bite-wing 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

MetLife Dental Plan

Covered Expenses (cont.)

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
- implants
- 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 5 years 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 or employer 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
- 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 you lose eligibility, benefits for covered expenses incurred before your plan terminates 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 plan terminates.

Exceptions to this 30 day extension include treatment involving:

- **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
- **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

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 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

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 by MetLife to be appropriate, 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

You should file a claim whenever you and your covered eligible dependents incur covered dental expenses. Claim forms are available from MetLife at www.metlife.com. Claims must be filed no later than 90 days after the plan year in which the services were rendered.

If you 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 claim 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.

Coordination of Benefits

The Dental Plan has a Coordination of Benefits (COB) provision 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. Your 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.

MetLife Dental Plan

Claims Review and Appeal Procedures

Initial Determination

After you submit a claim to MetLife for Dental Insurance benefits, MetLife will review your claim and notify you of its decision to approve or deny your claim. Such notification will be provided to you within a 30 day period from the date you submitted your claim, except for situations requiring an extension of time of up to 15 days because of matters beyond the control of MetLife. If MetLife needs such an extension, MetLife will notify you before the expiration of the initial 30 day period, state the reason why the extension is needed, and state when it will make its determination.

If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you of its claim decision. You will have 45 days to provide the requested information from the date you receive the notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline, or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline, or other criterion or indicate that such rule, protocol, guideline, or other criterion was relied upon and that you may request a free copy.

Appeals Procedure

If MetLife denies your claim, you may take two appeals of the initial determination. Upon your written request, MetLife will provide you with free copies of documents, records, and other information relevant to your claim.

You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why you are appealing the initial determination

As part of each appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination.

The person who will review your appeal will not be the same person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim.

If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination and will not be a subordinate of any person who was consulted on the initial determination.

MetLife Dental Plan

Claims Review and Appeal Procedures (cont.)

MetLife will notify you in writing of its final decision within 30 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you before the expiration of the initial 30 day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and that references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline, or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline, or other criteria or indicate that such rule, protocol, guideline, or other criteria was relied upon and that you may request a free copy. Upon written request, MetLife will provide you with free copies of documents, records, and other information relevant to your claim.

Delta Dental Plan

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Delta Dental Plan

How the Delta Dental Plan Works

Eligibility and Enrollment

The general eligibility and enrollment provisions can be found in the chapter titled “About Your Benefits.”

A subscriber or dependent who drops coverage, but 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 Retiree, Eligible Dependents, and Child(ren), refer to the “Glossary” and “About Your Benefits” chapters.

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 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 be responsible only 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 (preventive and diagnostic) 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 likely will be less if you choose a Participating Dentist.

Limitations

All time limitations are measured from the last date of service in the Delta Dental claims system and include service through other Delta Dental plans.

Delta Dental Plan

How the Delta Dental Plan Works

Types of Dental Services

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

- Class I: Preventive and diagnostic benefits
- Class II: Basic services
- Class III: Major services
- Class IV: Orthodontic services

Summary of Benefits

Refer to the "Schedule of Benefits" section on the following pages for details.

Services Covered	Amount of Coverage
Calendar Year Maximum (excludes diagnostic casts, cephalometric film, photos, and orthodontics)	\$1,500
Lifetime Orthodontic Maximum	\$1,500
Lifetime Maximum	NA
Annual Deductible (applies to Class II and Class III services only)	\$50

Services Covered	Amount of Coverage
CLASS I—Preventive and Diagnostic Services <i>Note: Members with certain high-risk medical conditions, such as diabetes, heart conditions, and high risk pregnancies, may be eligible for additional prophylaxes (cleanings) or fluoride treatment</i>	Covered 100%
• Oral Examinations	Two in a 12 month period
• Prophylaxis (cleanings)—includes periodontal maintenance	Two in a 12 month period
• Full Mouth X-rays	Once every 3 years
• Bite-wing X-rays	Two sets every 12 months
• Fluoride	Two in a 12 month period, under age 19
• Space Maintainers	Under age 14

Delta Dental Plan

Summary of Benefits (cont.)

Refer to the "Schedule of Benefits" section on the following pages for details.

Services Covered	Amount of Coverage
<p>CLASS II—Basic Services:</p> <ul style="list-style-type: none"> • Restorative (fillings) • General anesthesia • Occlusal guards (TMJ appliances are excluded) • Extractions • Oral surgery (extractions and dental surgery) • Periodontics (counts toward the oral exam benefit) • Endodontics (root canal therapy) • Emergency palliative treatment 	<p>Covered 80% after deductible</p>
<ul style="list-style-type: none"> • Sealants 	<p>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.</p>
<p>CLASS III—Major Services (no age limit for bridges, partial dentures, or full dentures)</p>	<p>Covered 50% after deductible</p>
<ul style="list-style-type: none"> • Crowns, Inlays, and Onlays 	<p>Porcelain, gold, or veneer crowns for children under age 12 are not a benefit</p>
<ul style="list-style-type: none"> • Bridges, Partial Dentures, and Full Dentures 	<p>Fixed bridges or cast partials for children under age 16 are not a benefit</p>
<ul style="list-style-type: none"> • Implants 	<p>Covered 50% after deductible, once every 60 months per tooth</p>
<p>CLASS IV—Orthodontic Services: for dependents up to age 26 (services, treatment, and procedures to correct malposed teeth, including braces)</p>	<p>Covered 50% up to the lifetime orthodontic maximum</p>

Delta Dental Plan

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 Services

- Oral Surgery—extractions and other surgical procedures (including pre- and postoperative 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 (TMJ appliances are excluded)

Class III—Major Services

- Cast Restorations—Crowns and onlays 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
- Implants and implant-related services are payable once per tooth in any 5 year period

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.

Orthodontic Payment Method

- a) 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.
- b) 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

Exclusions and Limitations

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. The Certificate was mailed to your home address when you enrolled. Contact Delta Dental for additional copies.*

Limitations and Exclusions on Preventive and Diagnostic Benefits

- a) 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.
- b) Full mouth x-rays are covered once within 3 years, unless special need is shown.
- c) Two sets of bite-wing x-rays in a 12 month period.
- d) Topical application of fluoride for members up to 19 years of age.
- e) Adult prophylaxis for members under 14 years of age is not allowed.
- f) Space maintainers for members age 14 and older are not allowed.

Limitations and Exclusions on Basic Benefits

- a) Restorative benefits are allowed once per surface in a 24 month period, regardless of the number or combinations of procedures requested or performed.
- b) 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 of the original root canal treatment by the same **dentist** or dental office.

- c) 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.
- d) The replacement, by the same dentist or dental office, of amalgam or composite restorations within 24 months is not a benefit.
- e) 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.
- f) 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.
- g) Gold foil restorations are an Optional Service.
- h) Porcelain, composite, and metal inlays are Optional Services.
- i) 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.
- j) Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).

Limitations and Exclusions on Major Benefits

- a) 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.
- b) A cast restoration on a tooth that can be restored with an amalgam or composite restoration is not a benefit.
- c) Procedures for purely cosmetic reasons are not benefits.

Delta Dental Plan

Exclusions and Limitations (cont.)

- d) Porcelain, gold, or veneer crowns for children under 12 years of age are not a benefit.
- e) Specialized implant surgical techniques are excluded.
- f) Replacement of any fixed bridges, or partial or complete dentures, that the member received in the previous 5 years is not a benefit.
- g) 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.
- h) 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.
- i) Payment for fixed bridges or cast partials for children under 16 years of age is not a benefit.
- j) A posterior bridge where a partial denture is constructed in the same arch is not a covered benefit.
- k) Temporary partial dentures are a benefit only when upper anterior teeth are missing.

Limitations and Exclusions on Orthodontic Benefits

- a) Orthodontic benefits are limited to eligible dependent children to age 26.
- b) Delta Dental shall make regular payments for orthodontic benefits.
- c) If orthodontic treatment began before 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.
- d) Benefits end with the next payment due the dentist after loss of eligibility or immediately if treatment stops.
- e) Benefits are not paid to repair or replace any orthodontic appliance received.
- f) 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.

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.

Delta Dental Plan

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.

General Provisions

This is a partial listing; please see your Dental Care Certificate for all exclusions and limitations. The Certificate was mailed to your home address when you enrolled. Contact Delta Dental for additional copies.

- 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. 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. 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 (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.

Delta Dental Plan

General Provisions (cont.)

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. Retiree

- The plan that covers you as a retiree 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.

Extended Dental Care Benefits

Coverage for any subscriber or eligible dependent terminates when he/she is 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.

Delta Dental Plan

Claims Review and Appeal Procedures

If you believe Delta Dental has not paid a claim properly, you should first attempt to resolve the problem by contacting Delta Dental.

Delta Dental will notify you or your authorized representative if you receive an adverse benefit determination after your claim is filed. An adverse benefit determination is any denial, reduction, or termination of the benefit for which you filed a claim, or a failure to provide or to make payment (in whole or in part) of the benefit you sought. This includes any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational or was not medically necessary or appropriate.

If Delta Dental informs you that the Plan will pay the benefit you sought but will not pay the total amount of expenses incurred, and you must make a Co-payment to satisfy the balance, you also may treat that as an adverse benefit determination.

If you receive notice of an adverse benefit determination, and if you think Delta Dental incorrectly denied all or part of your claim, you can take the following steps:

First, you or your Dentist should contact Delta Dental's Customer Service department at their toll-free number, (800) 524-0149, and ask them to check the claim to make sure it was processed correctly. You may also mail your inquiry to:

**Delta Dental
Customer Service Department
PO Box 9089
Farmington Hills, MI 48333-9089**

When writing, please enclose a copy of your Explanation of Benefits and describe the problem. Be sure to include your name, your telephone number, the date, and any information you would like considered about your claim. This inquiry is not required and should not be considered a formal request for review of a denied claim. Delta Dental provides this opportunity for you to describe problems and submit information that might indicate

your claim was improperly denied and allow Delta Dental to correct this error quickly.

Appeals Procedure

Whether or not you have asked Delta Dental informally, as described above, to recheck its initial determination, you can submit your claim to a formal review through the Claims Appeal Procedure described here. To request a formal appeal of your claim, you must send your request in writing to:

**Dental Director
Delta Dental
PO Box 30416
Lansing, MI 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 you also must 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 via certified mail, return receipt requested.

You or your authorized representative should seek a review as soon as possible, but you must file your appeal within 180 days of the date on which you receive your notice of the adverse benefit determination you are asking Delta Dental to review. If you are appealing an adverse determination of a Concurrent Care Claim, you will have to do so as soon as possible so that you may receive a decision on review before the course of treatment you are seeking to extend terminates.

The Dental Director or any other person(s) reviewing your claim will not be the same as, nor will they be subordinate to, the person(s) who initially decided your claim. The Dental Director will grant no deference to the prior decision about your claim. Instead, he will assess the information, including any additional information that you have provided, as if he were deciding the claim for the first time.

Delta Dental Plan

Claims Review and Appeal Procedures (cont.)

The Dental Director will make his decision within 30 days of receiving your request for the review of Pre-Service Claims and within 60 days for Post-Service Claims. If your claim is denied on review (in whole or in part), you will be notified in writing. The notice of any adverse determination by the Dental Director will:

- a) inform you of the specific reason(s) for the denial;
- b) list the pertinent Plan provision(s) on which the denial is based;
- c) contain a description of any additional information or material that is needed to decide the claim and an explanation of why such information is needed;
- d) reference any internal rule, guideline, or protocol that was relied on in making the decision on review and inform you that a copy can be obtained upon request at no charge;
- e) contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the Dental Director's decision to deny your claim (in whole or in part); and
- f) contain a statement that you may seek to have your claim paid by bringing a civil action in court if it is denied again on appeal.

If the Dental Director's adverse determination is based on an assessment of medical or dental judgment or necessity, the notice of his adverse determination will explain the scientific or clinical judgment on which the determination was based or include a statement that a copy of the basis for that judgment can be obtained upon request at no charge. If the Dental Director consulted medical or dental experts in the appropriate specialty, the notice will include the name(s) of the expert(s).

If your claim is denied in whole or in part after you have completed this required Claims Appeal Procedure, or if Delta Dental fails to comply with any of the deadlines contained therein, you have the right to seek to have your claim paid by filing a civil action in court. However, you will not be able to do so unless you have completed the review described above. If you wish to file your claim in court, you must do so within 1 year of the date on which you receive notice of the final denial of your claim.

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:

**Consumer Services Division
Ohio Department of Insurance
50 W. Town St., Third Floor, Suite 300
Columbus, OH 43215**

