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Summary Plan Description

Table of Contents

| | |
|---|---|
| Group Variables Page | i |
| Introduction..... | 1 |
| I. Eligibility and Enrollment of Subscribers and Dependents | 1 |
| II. Choosing a Dentist | 2 |
| III. General Provisions | 2 |
| IV. Benefits | 3 |
| V. Optional Services..... | 4 |
| VI. Schedule of Benefits..... | 4 |
| VII. Disclosure of Protected Health Information . | 6 |

Introduction

This Summary Plan Description (SPD) is a guide to your dental plan. It is not the contract between Delta Dental Plan of Tennessee (DDPT) and your group nor any member of the plan. Should there be any conflict between the SPD and the contract, the contract will prevail.

I. Eligibility and Enrollment of Subscribers and Dependents

Subscribers who have enrolled in this dental plan through their employer or other group sponsoring this plan may also enroll their dependents.

Dependents are defined as a lawful husband or wife or child(ren) from birth to their 24th birthday. "Child" includes a natural child, step-child, adopted child, foster child or child in the subscriber's legal custody. The child must be dependent on the subscriber for at least 50% of their support and maintenance and must not be married. A child 24 years of age or older may continue to be eligible provided they continue to meet the support, maintenance and marriage requirements. In addition, the child must not be able to support themselves because of mental incapacity or physical handicap. Such disabling condition will have begun before age 24. Proof of these facts must be given to DDPT or group within 31 days if requested. Proof will not be required more than once a year.

Dependents in military service are not eligible. Dependents must enroll along with the subscriber or as soon as they become dependents. If dependents do not enroll at this time, they must wait until the next open enrollment period to enroll. Dependents may not be enrolled without the enrollment of the subscriber, but the subscriber may drop dependent coverage and maintain their coverage.

A subscriber or dependent who drops their coverage but who still meets all requirements of the plan, may re-enroll during the first open enrollment period after having been out of the plan for 24 consecutive months.

Coverage for any subscriber or dependent terminates when they are no longer eligible for benefits as a member of the group. Specific state and federal laws or group policies may allow an extension of membership for a limited time. You should speak to the administrator of your group to see if an extension is available and for how long the benefits could be extended.

DDPT will not pay for any services received by a patient who is not eligible at the time of treatment. Coverage for subscribers and dependents is only effective after DDPT receives the premium for the period to be covered. If DDPT does not receive the premium when it is due, we may stop paying claims until payment is received. If premiums have not been received within 30 days after the due date, DDPT may cancel the contract with the group. DDPT does not bill individuals for premiums.

II. Choosing a Dentist

DDPT does not directly provide dental services and therefore is not liable for a dentist's refusal to provide services. It has contracted with "Participating Dentists". These dentists are independent contractors who have agreed to accept certain fees for the service they provide to

you. Dentists that have not contracted with Delta Dental are referred to as “Non-Participating Dentists”. The fact that a dentist has or has not chosen to participate with DDPT should not be viewed as a statement about their qualifications.

Although you are free to choose any dentist, your out of pocket expenses may be less if you choose a participating dentist. Therefore, you should always ask your dentist if he is a participating dentist or verify with DDPT that your dentist is a participating dentist before receiving any dental services.

DDPT is not responsible for any injuries or damages suffered due to the actions of any dentist. DDPT shares in the public concern over the spread of infectious disease, but it cannot require a dentist to be tested for them. Information about the need for clinical precautions as recommended by recognized health authorities is provided to dentists. If you have questions about your dentist’s health status or use of recommended clinical precautions, you should discuss them with your dentist.

III. General Provisions

- A. Participating dentists will file your claim with DDPT. If you need a claim form for services provided by a non-participating dentist you may contact DDPT which will provide you with a claim form. To be considered for benefits, a claim must be filed within 15 months of the date of service.
- B. If you require emergency dental care, you may seek services from any dentist. Your out of pocket expenses may be less if you choose a participating dentist.
- C. You may get an estimate of the cost of certain dental procedures before they are done. This estimate is referred to as a predetermination. You may have your dentist send DDPT a claim form detailing the projected treatment and DDPT will give an estimate of the benefits to be paid. 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.
- D. If you or your covered dependent receive an injury requiring dental treatment because of the action or fault of another person, and if

DDPT is unaware of other coverage, DDPT may pay benefits but would assume the subscriber’s or covered dependent’s rights to recover from the other person. The subscriber and covered dependent would be required to help DDPT in making such a recovery. This dental plan does not replace any workers’ compensation coverage.

- E. If a subscriber or covered dependent has two dental coverages, DDPT will coordinate benefits with the other coverage. The following rules will be used to determine which coverage should be primary.
 - 1. The program covering the patient as an employee is primary over a program covering the patient as a dependent.
 - 2. Where the patient is a dependent child, primary dental coverage will be determined by the date of birth of the parents. The coverage of the parent whose date of birth occurs earlier in the calendar year will be primary. For a dependent child of legally separated or divorced parents, the coverage of the parent with legal custody, or the coverage of the custodial parent’s spouse (i.e. stepparent) will be primary.
 - 3. If there is a court decree stating that one parent has financial responsibility for a child’s dental care expenses, any dependent coverage of that parent will be primary to any other dependent coverage.
- F. After a claim is processed, an Explanation of Benefits (EOB) will be sent to the subscriber. If any payment for services was denied, the EOB will give the reason why. If the subscriber disagrees with the denial he or she must submit a request in writing asking that the claim be reviewed. Such request should include the reason why the subscriber believes the claim was wrongly denied. The request must be received by DDPT within 180 days of the subscriber’s receipt of the EOB. DDPT will make a review and may ask for more documents if needed. Unless unusual circumstances arise, a decision will be sent to the subscriber within 30 days after DDPT receives the request for review.

If the subscriber does not agree with the first level review decision, he or she may refer the request for review to the Professional Relations Advisory Committee of DDPT. This

second level review request must be in writing and received by DDPT within a reasonable time after the subscriber receives the first level review decision. Unless unusual circumstances arise, a decision will be sent to the subscriber within 30 days after DDPT receives the request for second level review.

If the subscriber does not agree with the second level review decision, he or she may file civil action in court.

IV. Benefits

Not every dental procedure is a benefit of your dental plan nor are they paid at the same level of co-payment. The Schedule of Benefits in this SPD reflects the procedures that DDPT will cover as well as certain limitations and exclusions for these covered benefits. These services will be covered when a dentist or an employee of a dentist who is licensed to perform the service provides them. These services must be necessary and must be provided in accordance with generally accepted dental practice standards. Some allowable procedures are subject to deductibles, maximums, and copayments as described on the Group Variables Page.

In addition to the limitations and exclusions shown in the Schedule of Benefits section, DDPT does not pay for the following:

General Limitations and Exclusions

- A. Treatment of injury or illness covered by Workers' Compensation or Employer's Liability Laws.
- B. Services received without cost from any federal, state or local agency. This exclusion will not apply if prohibited by law.
- C. Cosmetic surgery or procedures for purely cosmetic reasons.
- D. Services for congenital (hereditary) or developmental malformations. Such malformations include, but are not limited to, cleft palate, or upper and lower jaw malformations. This does not exclude those services provided under Orthodontic benefits, if covered.
- E. Treatment to restore tooth structure lost from wear.
- F. Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion or treatment to stabilize the teeth. For example: equilibration, periodontal splinting and

- G. double abutments on bridges.
- G. Oral hygiene and dietary instructions, treatment for desensitizing teeth, prescribed drugs or other medication, experimental procedures, conscious sedation and extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- H. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility.
- I. Diagnosis or treatment for any disturbance of the temporomandibular joints (jaw joints) or myofascial pain dysfunction.
- J. Services by a dentist beyond the scope of his or her license.
- K. Dental services for which the patient incurs no charge.
- L. Dental services where charges for such services exceed the charge that would have been made and actually collected if no coverage existed.
- M. DDPT will apply the limitations and exclusions of this benefit plan base upon the member's complete and prior history as reflected in DDPT's records.

In the event a member transfers from one dentist to another during the course of treatment, payment by DDPT will be limited to the amount that would have been paid had only one dentist rendered the service.

V. Optional Services

In cases where alternate or optional methods of treatment exist, DDPT will pay for the least costly professionally accepted treatment. 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. If the treatment rendered is other than the covered benefit, the difference between DDPT's allowance and the dentist's fee, up to the approved amount, for the actual treatment rendered is due from the subscriber. For example, if your benefit plan allows for amalgams only even though a metal or porcelain inlay is suggested by your dentist, DDPT will pay for only the cost of the amalgam.

VI. Schedule of Benefits

In addition to the limitations and exclusions listed in the Schedule of Benefits, the **General Limitations and Exclusions** found in Section IV of this Summary Plan Description also apply.

A. Diagnostic and Preventive Benefits

- a) Diagnostic -- oral examination and x-rays to aid the dentist in planning required dental treatment.
- b) Preventive -- prophylaxis (cleaning), topical application of fluoride, and space maintainers.

Limitations and Exclusions On Diagnostic And Preventive Benefits

- a) Two oral exams and cleanings, to include periodontal maintenance procedures, in any 12-month period.
- b) Full mouth x-rays are covered once within 3 years, unless special need is shown.
- c) One set 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 are not allowed.
- f) Space maintainers for members more than 14 years of age are not allowed.

B. Basic Benefits

- a) Oral Surgery -- extractions and other surgical procedures (including pre- and post operative care).
- b) General Anesthesia & I.V. 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.
- c) Endodontia -- treatment of the dental pulp (root canal procedures).
- d) Periodontia -- treatment of the gums and bones that surround the tooth.
- e) Sealants -- resin filling used to seal grooves and pits on the chewing surface of permanent molar teeth.
- f) Denture Repairs -- services to repair complete or partial dentures.
- g) Basic Restorations -- amalgams (silver fillings) composites (white fillings) and prefabricated stainless steel crown restorations for the treatment of decay.

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 by the same dentist or dental office.
- c) Payment for periodontal surgery shall include charges for three months post operative care and any surgical re-entry for a three year period. Root planing, curettage and osseous surgery are not a benefit for members under 14 years of age.
- d) 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.
- e) The replacement, by the same dentist or dental office, of amalgam or composite restorations within 24 months is not a benefit.
- f) 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.
- g) 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.
- h) Gold foil restorations are an Optional Service.
- i) Porcelain, composite, and metal inlays are Optional Services.

C. Major Benefits

- a) 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.
- b) Prosthodontics -- Procedures for construction of fixed bridges, partial or complete dentures and repair of fixed bridges.

- c) Complete or Partial Denture Reline -- Chair side or laboratory procedure to improve the fit of the appliance to the tissue (gums).
- d) Complete or Partial Denture Rebase -- Laboratory replacement of the acrylic base of the appliance.

Limitations and Exclusions On Major Benefits

- a) Replacement of crowns or cast restorations received in the previous five 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.
- d) Porcelain, gold or veneer crowns for children under 12 years of age are not a benefit.
- e) Replacement of any fixed bridges or partial or complete dentures that the member received in the previous five years is not a benefit.
- f) Payment for a complete or partial denture shall include charges for any necessary adjustment within a six month period. Payment for a reline or rebase of a partial or complete denture is limited to once in a three year period and includes all adjustments required for six months after delivery.
- g) 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.
- h) Payment for implants (artificial materials implanted into or on bone or gums) or their removal is not a benefit. However, an allowance for a standard complete or partial denture toward the cost of replacing multiple missing teeth will be

made. For single tooth implants, DDPT will make an allowance for a crown but not for the placement of the implant.

- 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.

D. Orthodontic Benefits

As shown on the Group Variables page, DDPT 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.

Limitations and Exclusions On Orthodontic Benefits

- a) Orthodontic benefits are limited to members shown on the Group Variables Page.
- b) DDPT shall make regular payments for orthodontic benefits.
- c) If orthodontic treatment began prior to enrolling in this plan, DDPT will begin benefits with the first payment due the dentist after the subscriber or covered 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 are not paid for extractions or other surgical procedures. However, these additional services may be covered under Diagnostic and Preventive or Basic Benefits.

Orthodontic Payment Method

- a) The initial payment (initial banding fee) made by DDPT 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.

VII. Disclosure of Protected Health Information to Team Health

Delta Dental may disclose Summary Health Information to Team Health for the purpose of obtaining premium bids for providing coverage under the Plan or for modifying, amending, or terminating the Plan.

The Plan will disclose Personal Health Information (PHI) to the Employer only in accordance with the established HIPAA guidelines. PHI disclosed to Team Health may only be used for permitted and required uses and disclosures.

Additionally, the Employer agrees:

- Not to use or further disclose PHI other than as permitted or as required by law;
- To ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions;
- Not to use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;
- To report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures.
- To make PHI available to individuals in accordance with HIPAA regulations
- To make PHI available for individuals' amendment and incorporate any amendments in accordance with HIPAA regulations.
- To make the information available that will provide individuals with an accounting of disclosures in accordance with HIPAA regulations.
- To make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request;
- If feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible.

- To ensure that adequate separation between the Plan and the Employer, as required by HIPAA regulations

Access to and use of PHI will be restricted to Plan Administration Functions that the Employer performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.