Delta Dental Medicare Advantage™ Dental Plan

Welcome!

Good oral health is a vital part of good general health, and your Delta Dental program is designed to promote regular dental visits. We encourage you to take advantage of this program by calling your Dentist today for an appointment.

This Member Handbook which includes your Covered Code List describes the specific benefits of your Delta Dental program and how to use them. If you have any questions about this program, please call our Customer Service department at 888-965-4721 (TTY Users call 711).

You can easily verify your own benefit, claims and eligibility information online 24 hours a day, seven days a week by visiting https://www.DeltaDentalNC.com and selecting the link for our Member Portal. The Member Portal will also allow you to print claim forms, select paperless Explanation of Benefits statements (EOBs), search our Dentist directories, and read oral health tips.

We look forward to serving you!

Medicare Advantage Supplemental Dental Plan
HealthTeam Advantage
Group Number - 2000
Subgroup Number – 0004, 0005

***Services received from dentists who do NOT participate in the Delta Dental Medicare Advantage Network will result in your out of pocket costs being higher.**

IMPORTANT: If you receive services from a dentist that DOES NOT participate in Delta Dental's Medicare Advantage Network YOU WILL BE RESPONSIBLE for the difference between Delta Dental's payment and the amount charged by the Nonparticipating dentist.

Benefit Year – January 1 through December 31

Maximum Payment**:** **In-Network:** $3,000 per person total per Calendar year for Preventive and Comprehensive services combined.

Out-of-Network: $500 per person total per Calendar Year for Preventive and Comprehensive services combined. This $500 maximum amount is part of the overall $3,000 amount for the Calendar Year and **NOT** in addition to the $3,000 amount.

Deductible: $50 Deductible – applies to comprehensive services.

This section provides a list of dental procedures covered by your plan. **If a procedure is not on this list, it is not a covered benefit under your plan.** Benefit limitations under these programs are listed where applicable in the Benefit Limitations column. Some services share frequencies. Additional information on the frequency limitations can be found in this Delta Dental Member Handbook.

*Please note, certain procedures may require review or diagnostic information such as radiographs or patient treatment records for claims processing and final payment determinations. **If further clarification regarding your coverage and benefits is needed, please ask your dentist for a Pre-Service Organization Determination (PSOD).**

PSOD's expire at the end of the benefit year. Once a new benefit year begins, it is recommended another request for a PSOD is submitted to determine whether the service is covered under the current benefit plan.

It may be necessary for codes listed to be changed to comply with State, Federal, and American Dental Association (ADA) regulations. The ADA codes are subject to annual updates which may not be reflected in the list provided.

Services for which Delta Dental will provide an allowance for optional treatment is indicated within the Frequency column of the Covered Code List, if applicable. Remember, you are responsible for the difference in the cost for any optional treatment and the payment made by Delta Dental.

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
Preventive				
D0100-D0999 & 9430 Diagnostic				
D0120	periodic oral evaluation - established patient	100%	50%	Twice per calendar year
D0140	limited oral evaluation - problem focused	100%	50%	Once per six month period or as needed for diagnosis of emergency condition
D0150	comprehensive oral evaluation - new or established patient	100%	50%	Once per three year period
D0170	re-evaluation - limited, problem focused (established patient; not post-operative visit)	100%	50%	Twice per calendar year
D0210	intraoral - complete series	100%	50%	Once per calendar year
D0220*, D0230*	intraoral/extra-oral periapical image	100%	50%	2 per 12 month period
D0270, D0272, D0273, D0274,	bitewing x-rays	100%	50%	Up to 4 images per 12 month period
D0330	panoramic image	100%	50%	Once per calendar year
D9430	office visit for observation (during regularly scheduled hours) - no other services performed	100%	50%	Once per six month period

Diagnostic Notes: • Bitewing x-rays are covered, except in the years when you get the full-mouth or panoramic x-ray. • Oral examinations and evaluations (not including limited problem focused evaluations or patient screenings) share frequencies.				
D1000-D1999 Preventive				
D1110	prophylaxis - adult	100%	50%	Twice per calendar year
Preventive Notes: • Teeth cleanings (prophylaxes and periodontal cleanings) are payable twice per calendar year. • Prophylaxis is only payable on natural teeth.				
Comprehensive Services - $50 Deductible Applies				
D2000-D2999 Restorative				
D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394	amalgam and resin based composite restoration, anterior and posterior	100%	50%	4 per calendar year
D2740*, D2750*, D2751*, D2752*	crown - porcelain/ceramic	80%	50%	2 per calendar year
D2791*, D2792*	crown - full cast predominantly base metal	80%	50%	2 per calendar year
D2915*	re-cement or re-bond indirectly fabricated or prefabricated post and core	80%	50%	Covered service
D2920*	re-cement or re-bond crown	80%	50%	Covered service
D2921*	reattachment of tooth fragment, incisal edge or cusp	80%	50%	Covered service
D2928*, D2929*, D2930*, D2931*, D2932*, D2933*, D2934*	prefabricated crown	80%	50%	Covered Service
D2940	protective restoration	80%	50%	Once per tooth per lifetime and considered to be part of the fee when done in conjunction with a definitive restoration, indirect pulp cap or endodontic treatment (including pulpotomy)

D2949*	restorative foundation for an indirect restoration	80%	50%	Covered Service
D2950*	core buildup, including any pins when required	80%	50%	Once per 5 year period
D2951*	pin retention - per tooth, in addition to restoration	80%	50%	Once per tooth per lifetime
D2952*, D2954*	post and core in addition to crown	80%	50%	Once per 5 year period
D2953*	each additional indirectly fabricated post - same tooth	80%	50%	Once per 5 year period
D2955*	post removal	80%	50%	Covered service
D2957*	each additional prefabricated post - same tooth	80%	50%	Covered service
D2971*	additional procedures to customize a crown to fit under an existing partial denture framework	80%	50%	Subject to procedure review
D2980*	crown repair necessitated by restorative material failure	80%	50%	Covered service

Restorative Notes:

- Subsequent minor restorations would not be a benefit within that five-year period on crowns on onlays.
- Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture (lost or mobile tooth structure). Our standard for extensive loss of tooth structure is 50% tooth loss.
- Participating dentists may not charge members for recementation of a crown, onlay, inlay, or bridge within 6 months of the seating date.
- When implants are NOT covered, crowns over implants are not covered.
- Crowns on bridges are NOT covered if bridges are NOT covered.
- Amalgam and composite resin restorations are payable once in any two-year period by the same dentist, same tooth and same surface, regardless of the number or combination of restorations placed on a surface.

D3000-D3999 Endodontics				
D3220*	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	80%	50%	Covered service
D3221*	pulpal debridement, primary or permanent teeth	80%	50%	Covered service
D3222*	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	80%	50%	Once per tooth per lifetime; additional benefit will require
D3230*, D3240*	pulpal therapy (resorbable filling) - any tooth (excluding final restoration)	80%	50%	Covered service
D3310*, D3320*, D3330*	endodontic therapy (excluding final restoration)	80%	50%	Covered service
D3332*	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	80%	50%	Covered service
D3333*	internal root repair of perforation defects	80%	50%	Covered service

D3346*, D3347*, D3348*	retreatment of previous root canal therapy	80%	50%	Covered service
D3351*, D3352*, D3353*	apexification/recalcification	80%	50%	Covered service
D3410*, D3421*, D3425*, D3426*	apicoectomy	80%	50%	Covered service
D3430*	retrograde filling - per root	80%	50%	Covered service
D3450*	root amputation - per root	80%	50%	Covered service
D3471*, D3472*, D3473*	surgical repair of root resorption	80%	50%	Covered service
D3501*, D3502*, D3503*	surgical exposure of root surface without apicoectomy or repair of root resorption	80%	50%	Covered Service
D3920*	hemisection (including any root removal), not including root canal therapy	80%	50%	Covered service
D3999*	unspecified endodontic procedure, by report	80%	50%	Benefit determined by consultant review
D4000-D4999 Periodontics				
D4341*	periodontal scaling and root planing - four or more teeth per quadrant	100%	50%	4 quadrants per two years
D4342*	periodontal scaling and root planing - one to three teeth per quadrant	100%	50%	4 quadrants per two years
D4355*	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	100%	50%	Once per two-year period
Periodontic Notes: • Root planing is payable once in any 2 year period.				
D5000-D5999 Prosthodontics (Removable)				
D5110*	complete denture - maxillary	80%	50%	Full **OR** partial dentures once per five-year period
D5120*	complete denture - mandibular	80%	50%	
D5130*	immediate denture - maxillary	80%	50%	
D5140*	immediate denture - mandibular	80%	50%	
D5211*	maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	80%	50%	
D5212*	mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	80%	50%	

D5213*	maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	80%	50%	
D5214*	mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	80%	50%	
D5410*	adjust complete denture - maxillary	80%	50%	Covered service
D5411*	adjust complete denture - mandibular	80%	50%	Covered service
D5421*	adjust partial denture - maxillary	80%	50%	Covered service
D5422*	adjust partial denture - mandibular	80%	50%	Covered service
Prosthodontic (Removable) Notes: • One complete upper denture and one complete lower denture, and any implant used to support a denture are payable once in any five-year period. • A removable partial denture, endosteal implant (other than to support a denture), or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance. • The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.				
D6000-D6199 Implant Services				
D6010*	surgical placement of implant body; endosteal implant	80%	50%	Once per tooth per 5 year period
D6013*	surgical placement of mini implant	80%	50%	Once per 5 year period
D6056*	prefabricated abutment - includes modification and placement	80%	50%	Once per 5 year period
D6057*	custom abutment - includes placement	80%	50%	Once per 5 year period
D6058*, D6059*, D6060*, D6061*, D6062*, D6063*, D6064*	abutment supported crown, any material	80%	50%	Once per 5 year period
D6065*, D6066*, D6067*, D6082*, D6083*, D6084*, D6086*, D6087*, D6088*	implant supported crown, any material	80%	50%	Once per 5 year period

D6068*, D6069*, D6070*, D6071*, D6072*, D6073*, D6074*	abutment supported retainer for fixed partial denture	80%	50%	Once per 5 year period
D6075*, D6076*, D6077*	implant supported retainer for fixed partial denture	80%	50%	Once per 5 year period
D6200-D6999 Prosthodontics (Fixed)				
D6205*, D6245*,	pontic – indirect resin based composite or porcelain/ceramic	80%	50%	Once per 5 year period
D6210*, D6211*, D6212*, D6214*,	pontic	80%	50%	Once per 5 year period
D6240*, D6241*, D6242*, D6243*,'	pontic – porcelain fused	80%	50%	Once per 5 year period
D6250*, D6251*, D6252*,	pontic - resin	80%	50%	Once per 5 year period
D6545*	retainer – cast metal for resin bonded fixed prosthesis	80%	50%	Once per 5 year period per consultant review
D6548*	retainer – porcelain/ceramic for resin bonded fixed prosthesis	80%	50%	Once per 5 year period per consultant review
D6549*	resin retainer - for resin bonded fixed prosthesis	80%	50%	Once per 5 year period per consultant review
D6602*, D6603*	retainer inlay - cast high noble metal	80%	50%	Once per 5 year period per consultant review
D6604*, D6605*	retainer inlay - cast predominantly base metal,	80%	50%	Once per 5 year period per consultant review
D6606*, D6607*	retainer inlay - cast noble metal	80%	50%	Once per 5 year period per consultant review
D6608*, D6609*	retainer onlay - porcelain/ceramic	80%	50%	Once per 5 year period per consultant review
D6610*, D6611*	retainer onlay - cast high noble metal	80%	50%	Once per 5 year period per consultant review
D6612*, D6613*	retainer onlay - cast predominantly base metal	80%	50%	Once per 5 year period per consultant review
D6614*, D6615*	retainer onlay - cast noble metal	80%	50%	Once per 5 year period per consultant review

D6624*	retainer inlay - titanium	80%	50%	Once per 5 year period per consultant review
D6634*	retainer onlay - titanium	80%	50%	Once per 5 year period per consultant review
D6720*, D6721*, D6722*	retainer crown - resin with high noble metal	80%	50%	Once per 5 year period
D6740*	retainer crown - porcelain/ceramic	80%	50%	Once per 5 year period
D6750*, D6751*, D6752*, D6753*	retainer crown - porcelain fused to high noble metal	80%	50%	Once per 5 year period
D6780*, D6781*, D6782*, D6783*, D6784*	retainer crown - 3/4 cast high	80%	50%	Once per 5 year period per consultant review
D6790*, D6791*, D6792*, D6794*	retainer crown - full cast high noble metal	80%	50%	Once per 5 year period per consultant review
D6930*	re-cement or re-bond fixed partial denture	80%	50%	Covered service
D6980*	fixed partial denture repair, necessitated by restorative material failure	80%	50%	Covered service
D6999	unspecified fixed prosthodontic procedure, by report	80%	50%	Benefit determined by consultant review
Implant Services Notes: • Participating dentists may not charge members for Recementation or rebonding of partial dentures within 6 months of the seating date.				
D7000-D7999 Oral and Maxillofacial Surgery				
D7140*	extraction, erupted tooth or exposed root (elevation and or forceps removal)	80%	50%	4 per Calendar Year
D7210*	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated	80%	50%	

Definitions

Adverse Benefit Determination

Any denial, reduction or termination of the benefits for which you filed a claim. Or a failure to provide or to make payment (in whole or in part) of the benefits you sought, including 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.

Allowed Amount

The amount permitted under the Medicare Advantage Dentist Fee Schedule which Delta Dental will base its payment for a Covered Service.

Appeal

The procedures that deal with the review of adverse initial determination for payment of services.

Benefit Year

The calendar year.

Benefits

Payment for the Covered Services that have been selected under This Plan.

Completion Dates

The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- For dentures and partial dentures, on the delivery dates;
- For crowns and bridgework, on the permanent cementation date;
- For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Coinsurance

The percentage of the charge, if any, that you must pay for Covered Services.

Copayment

A fixed amount of money that you must pay for Covered Services, if any.

Covered Code List

The unique list of the ADA dental codes that are covered services under This Plan. These codes are subject to the terms of this Member Handbook.

Covered Services

The unique dental services selected for coverage as described in this Member Handbook.

Deductible

The amount a person must pay toward Covered Services before Delta Dental begins paying for those services under this Member Handbook. If applicable, the deductible that applies to you is listed at the beginning of this Member Handbook.

Delta Dental

Delta Dental of North Carolina is a nonprofit dental care corporation doing business as Delta Dental of North Carolina. Delta Dental is not an insurance company. Delta Dental of North Carolina has been delegated by your Health Plan to provide dental benefits for This Plan.

Dental Emergency

A Dental Emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; Serious impairment to bodily functions; or Serious dysfunction of any bodily organ or part.

Dentist

A person licensed to practice dentistry in the state or jurisdiction in which dental services are performed.

- **Delta Dental Medicare Advantage** – a Dentist located in North Carolina who has signed an agreement with Delta Dental for this Plan that is part of Delta Dental's Medicare Advantage Network.
- **Nonparticipating Dentist** – a Dentist who has not signed an agreement with Delta Dental to become part of the Delta Dental Medicare Advantage Network or is located in a state other than North Carolina.
- **Out-of-Country Dentist** – a Dentist whose office is located outside the United States and its territories. These dentists are nonparticipating because Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.
- **IMPORTANT: If you receive services from a dentist that <u>DOES NOT</u> participate in Delta Dental's Medicare Advantage Network <u>YOU WILL BE RESPONSIBLE</u> for the difference between Delta Dental's payment and the amount charged by the Nonparticipating dentist.**

Grievance

An expression of dissatisfaction (other than a coverage determination) with any aspect of the operations, activities or behavior of Delta Dental, your MAO or a Dentist that has provided dental services under This Plan.

Inquiry

A verbal or written request for information that does not involve a grievance, coverage or appeals process, such as a routine question about a benefit.

Maximum Approved Fee

The maximum fee that Delta Dental approves for a given procedure in a given region and/or specialty, under normal circumstances, based upon applicable Medicare Advantage Participating Dentist schedules and internal procedures.

Maximum Payment

The maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services.

Medicare Advantage Dentist Fee Schedule

The maximum fee allowed per procedure for services rendered by a Delta Dental Medicare Advantage Dentist as determined by Delta Dental.

Member

A person with coverage under This Plan.

Member Handbook

Delta Dental will provide Benefits as described in this Member Handbook. Any changes in this Member Handbook will be based on changes to the contract between Delta Dental and your Medicare Advantage Organization (MAO).

Nonparticipating Dentist Fee

The maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist as determined by Delta Dental.

Post-Service Claims

Claims for Benefits that are not conditioned on your seeking advance approval, certification, or authorization to receive the full amount for any Covered Services. In other words, Post-Service Claims arise when you receive the dental service or treatment before you file a claim for Benefits.

Pre-Service Organization Determination

A determination that is made prior to receiving dental services based on your benefits and coverage. This decision will determine whether a dental service will be covered and will provide information on how much you may have to pay for this service. This is a request submitted by you or your Dentist.

Pre-Treatment Estimate

An estimate of the cost for a planned treatment. Pre-treatment estimates are not required before treatment.

Processing Policies

Delta Dental's policies and guidelines used for Pre-Service Organization Determinations and payment of claims. The Processing Policies may be amended from time to time. Processing Policies may limit Delta Dental's payment for services or supplies.

Submitted Amount

The amount a Dentist bills to Delta Dental for a specific treatment or service. A Delta Dental Medicare Advantage Participating Dentist cannot charge you for the difference between this amount and the amount Delta Dental approves for the treatment.

This Plan

The dental coverage established for Eligible Persons pursuant to this Member Handbook.

Selecting a Dentist

To receive benefits under This Plan you must receive services from a Delta Dental Medicare Advantage Dentist. **Services received from dentists who do NOT participate in the Delta Dental Medicare Advantage Network will result in your out of pocket costs being higher.**

To verify that a Dentist is a Medicare Advantage Participating Dentist, you can use Delta Dental's online Dentist Directory at www.deltadentalnc.com or call 888-965-1965 (TTY Users call 711). **.**

IMPORTANT: If you receive services from a dentist that DOES NOT participate in Delta Dental's Medicare Advantage Network YOU WILL BE RESPONSIBLE for the difference between Delta Dental's payment and the amount charged by the Nonparticipating dentist.

Accessing Your Benefits

To utilize your dental benefits, follow these steps:

1. Please read this Member Handbook carefully so you are familiar with your benefits, payment methods, and terms of This Plan.
2. Make an appointment with your Dentist and tell him or her that you have dental benefits with Delta Dental's Medicare Advantage Dental Plan. If your Dentist is not familiar with This Plan or has any questions, have him or her contact Delta Dental by calling the toll-free number at 855-253-4721 or, by writing to Delta Dental:

Attention: Customer Service
P.O. Box 9230
Farmington Hills, MI 48333-9230

3. After you receive your dental treatment, you or the dental office staff will file a claim form, completing the information portion with:

   a. Your full name and address
   b. Your Member ID number
   c. Your date of birth

Notice of Claim Forms

Your Dentist should submit your dental claims form using the most recent American Dental Association ("ADA") approved claim form. Medicare Advantage Participating Dentists will fill out and submit your dental claims for you.

Mail claims and completed information requests to:

Delta Dental
PO Box 9298
Farmington Hills, MI 48333

Pre-Service Organization Determinations

Your Dentist can submit a request for a coverage decision to determine whether you qualify for a dental service that may be covered under This Plan through the Dental Office Toolkit ® (DOT). You can also request a coverage decision to determine whether you qualify for a dental service that may be covered under This Plan by calling the Customer Service department toll-free at 888-965-1965 or in writing at:

Attention: Customer Service
P.O. Box 9230
Farmington Hills, MI 48333-9230

For a standard pre-service coverage decision, Delta Dental will provide an answer within 14 calendar days after receiving your request. To file a fast coverage decision the standard deadlines must potentially cause serious harm to your health or hurt your ability to function. If Delta Dental approves the fast request, an answer will be provided within 72 hours. For both standard and fast requests, Delta Dental may take up to 14 additional calendar days under certain circumstances. If additional time is taken, Delta Dental will notify you in writing and explain the reasons for the extension.

If Delta Dental does not approve your standard or fast coverage request, you have the right to file an appeal. Please see the Appeal section for more information. Availability of dental benefits at the time your request is completed is dependent on several factors. These factors include, but are not limited to, medical necessity, your continued eligibility for benefits, your available annual or lifetime Maximum Payments, any coordination of benefits, the status of your Dentist, This Plan's limitations and any other provisions, together with any additional information or changes to your dental treatment. To determine whether a service may be covered under This Plan, please review the benefits included in this document.

Written Notice of Claim and Time of Payment

All claims for Benefits must be filed with Delta Dental within one year of the date the services were completed. Once a claim for payment is filed, Delta Dental will decide it within 30 days of receiving it. If there is not enough information to decide your claim, Delta Dental will notify you or your Dentist within 30 days. The notice will (a) describe the information needed, (b) explain why it is needed, (c) request an extension of time in which to decide the claim, and (d) inform you or your Dentist that the information must be received within 60 days or your claim will be denied. You will receive a copy of any notice sent to your Dentist. Once Delta Dental receives the requested information, it will decide your claim and send you notice of that decision. If you or your Dentist does not supply the requested information, Delta Dental will have no choice but to deny your claim. Once Delta Dental decides your claim, it will notify you within five days.

Authorized Representative

You may also appoint an authorized representative to deal with Delta Dental on your behalf with respect to any benefit claim you file or any review of a denied claim you wish to pursue (see the Grievance and Appeals Procedure section). You should call Delta Dental's Customer Service department, toll-free, at 888-965-1965, or write them at:

HealthTeam Advantage
Attn: Appeals and Grievances
300 E. Wendover Ave. Suite 121
Greensboro, NC 27401

To request a form to designate the person you wish to appoint as your representative or you may use the CMS Appointment of Representative Form (Form CMS-1696). While in some circumstances your Dentist is treated as your authorized representative, generally HealthTeam Advantage only recognizes the person whom you have authorized on the last dated form filed with Delta Dental. Once you have appointed an authorized representative, HealthTeam Advantage will communicate directly with your representative and will not inform you of the status of your claim. You will have to get that information from your representative. If you have not designated a representative, HealthTeam Advantage will communicate directly with you.

How Payment is Made

If your Dentist is a Medicare Advantage Participating Dentist, Delta Dental will base payment on the Maximum Approved Fee for Covered Services.

Delta Dental will send payment directly to the Medicare Advantage Participating Dentists and you will be responsible for any applicable Coinsurance, Copayments or Deductibles.

If you receive services from a dentist that DOES NOT participate in Delta Dental's Medicare Advantage Network YOU WILL BE RESPONSIBLE for the difference between Delta Dental's payment and the amount charged by the Nonparticipating dentist.

Exclusion and Limitations

Exclusions

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in this Member Handbook. All charges for the same will be your responsibility (though your payment obligation may be satisfied by insurance or some other arrangement for which you are eligible):

1. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations.
2. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
3. Services started or appliances started before a person became eligible under This Plan.
4. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions, and relative analgesia.
5. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
6. Charges for hospitalization, laboratory tests, and histopathological examinations.
7. Charges for failure to keep a scheduled visit with the Dentist.
8. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
9. Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
10. Services or supplies, as determined by Delta Dental, which are specialized techniques.

11. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist or other dental professional, as determined by Delta Dental under the scope of his or her license as permitted by applicable state law.
12. Services or supplies for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
13. Services or supplies received due to an act of war, declared or undeclared or terrorism.
14. Services or supplies covered under a hospital, surgical/medical or prescription drug program.
15. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
16. Interim caries arresting medicament.
17. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
18. Lost, missing, or stolen appliances of any type.
19. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting.
20. Paste-type root canal fillings on permanent teeth.
21. Replacement, repair, relines or adjustments of occlusal guards.
22. Chemical curettage.
23. Services associated with overdentures.
24. Implant/abutment supported interim fixed denture for edentulous arch.
25. Metal bases on removable prostheses.
26. The replacement of teeth beyond the normal complement of teeth.
27. Personalization or characterization of any service or appliance.
28. Temporary crowns used for temporization during crown or bridge fabrication.
29. Posterior bridges in conjunction with partial dentures in the same arch, sharing at least one posterior edentulous space in common.
30. Precision attachments and stress breakers.
31. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
32. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
33. Diagnostic photographs and cephalometric films.
34. Myofunctional therapy.
35. Mounted case analyses.
36. Any and all taxes applicable to the services.
37. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.
38. Biologic materials to aid in soft and osseous tissue regeneration when submitted on the same day as tooth extraction, periradicular surgery, soft issue grafting, guided tissue regeneration, implants, ridge augmentation, ridge preservation/extraction sites, periradicular surgery, apicoectomy sites, hemisections, and periodontal or implant bone grafting.

Delta Dental will make no payment for the following services or supplies. Medicare Advantage Participating Dentists may not charge Members for these services or supplies. All charges from Nonparticipating Dentists for the following are your responsibility:

1. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
2. The completion of forms or submission of claims.

3. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.
4. Local anesthesia.
5. Acid etching, cement bases, cavity liners, and bases or temporary fillings.
6. Infection control.
7. Temporary, interim, or provisional crowns.
8. Gingivectomy as an aid to the placement of a restoration.
9. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
10. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
11. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.
12. Post-operative X-rays, when done following any completed service or procedure.
13. Periodontal charting.
14. Pins and preformed posts, when done with core buildups for crowns, onlays, or inlays.
15. Any substructure when done for inlays, onlays, and veneers.
16. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.
17. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
18. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
19. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
20. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.
21. A prophylaxis when done on the same day a periodontal maintenance or scaling and root planing.
22. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
23. Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within 30 days of three or four quadrants of scaling and root planing or other periodontal treatment.
24. Full mouth debridement when done within 30 days of scaling and root planing.
25. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant services without flap entry and closure, when performed within 12 months of implant restorations, provisional implant crowns and implant or abutment supported interim dentures.
26. Scaling and debridement in the presence of inflammation or mucositis of a single implant, when done on the same day as a prophylaxis, scaling in the presence of gingival inflammation, periodontal maintenance, full mouth debridement, periodontal scaling and root planing, periodontal surgery or debridement of a peri-implant defect.
27. Full mouth debridement, when done on the same day as comprehensive evaluation.
28. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
29. Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.
30. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
31. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period of time of performing panoramic and/or full mouth X-rays, as determined solely by Delta Dental.

32. Charges or fees for overhead, internet/video connections, software, hardware or other equipment necessary to deliver services, including but not limited to teledentistry services.

33. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Limitations

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in this Member Handbook. In addition to the limitations listed in the Covered Code List all charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the applicable prior dates of services in our records or, at the request of your Medicare Advantage Organization, any dental plan:

1. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture (lost or mobile tooth structure). Our standard for extensive loss of tooth structure is 50% tooth loss.

2. When services in progress are interrupted, Delta Dental will not issue payment for any incomplete services; however, Delta Dental will calculate the Maximum Approved Fee that the dentist may charge you for such incomplete services, and those charges will be your responsibility. In the event the interrupted services are completed later by a Dentist, Delta Dental will review the Claim to determine the amount of payment, if any, to the Dentist in accordance with Delta Dental's policies at the time services are completed.

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. Not all services are covered by your plan, but if a service is covered, certain limitations may apply. However, Medicare Advantage Participating Dentists may not charge Members for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the applicable prior dates of services in our records or, at the request of your Medicare Advantage Organization, any dental plan:

1. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.

2. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.

Coordination of Benefits

Coordination of Benefits ("COB") provision applies when a Person has health care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans does not exceed 100 percent of the total Allowable Expense.

Definitions

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: group and non-group insurance contracts, medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; or coverage under other federal governmental plans that do not permit coordination.

Each contract for coverage under (1) or (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan, for purposes of this section, means the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order of Benefit Determination Rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its Benefits first before those of any other Plan without considering any other Plan's Benefits. When This Plan is secondary, it determines its Benefits after those of another Plan and may reduce the Benefits it pays so that the total benefits paid by all Plans do not exceed the Submitted Amount. In no event will This Plan's payments exceed the Maximum Approved Fee.

Order of Benefits Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. This Plan will pay primary over any Medicaid or Retiree or Individual Plan that you may have.

2. This Plan will pay secondary to any employer sponsored, automobile, or group plan you may have, except for those listed in (1) above.

3. If This Plan is the Primary Plan, it will pay its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

4. Except as provided in the following paragraph, a Plan that does not contain a COB provision is always primary unless otherwise required by law.

   Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, shall be secondary regardless of whether or not it contains a COB provision.

5. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Effect on the Benefits of This Plan

When This Plan is secondary, it may reduce its Benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Submitted Amount. In determining the amount to be paid, This Plan will calculate the benefits it would have paid in the absence of other health care coverage (Maximum Approved Fee) and apply that the remaining amount that you owe to the Dentist following the Primary Plan's payment. The amount paid by This Plan will not exceed the Maximum Approved Fee.

Right of Recovery

If the amount of the payments made by Delta Dental is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. You or your Dentist should contact Delta Dental's Customer Service department and ask them to check the claim to make sure it was processed correctly. You may do this by calling the toll-free number, 888-965-1965, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at:

Attention: Customer Service
P.O. Box 9230
Farmington Hills, MI 48333-9230

You may also follow the Grievance and Appeals Procedure below.

Grievance and Appeals Procedures

If we make an Adverse Benefit Determination, you will receive a Notice of Denial of Coverage. You or your authorized representative, should seek a review as soon as possible, but you must file your request for review within **60 days** of the date that you received that Notice of Denial of Coverage. Delta Dental may give you more time if you have a good reason for missing the deadline.

There are two types of appeals.

Standard Appeal – We will give you a written decision on a standard appeal within 30 days after we get your appeal for a Pre-Service Organization Determination. Our decision might take longer if you ask for an extension, or if we need more information about your case. We will tell you if we are taking extra time and will explain why more time is needed. If your appeal is for payment of a service you have already received, we will give you a written decision within 60 days.

Fast Appeal – We will give you a decision on a fast appeal within 72 hours after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 Days for a decision. You cannot request a fast appeal if you are asking us to pay you back for a service you have already received.

Send appeals to the following:

HealthTeam Advantage
Attn: Appeals and Grievances
300 E. Wendover Ave. Suite 121
Greensboro, NC 27401

Fax: 800-845-4104
Phone: 888-965-1965
TTY: 711

Please include your name and address, the Member ID, the explanation of benefits, the reason why you believe your claim was wrongly denied, and any other information you believe supports your claim. Indicate in your letter that you are requesting a formal appeal (Standard/Fast Appeal) of your claim. You also have the right to review any documents related to your appeal. If you would like a record of your request and proof that HealthTeam Advantage received it, mail your request certified mail, return receipt requested.

If you want someone else to act for you, you can name a relative, friend, attorney, dentist or someone else to act as your representative. You can do this by following the authorized representative section above. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You will need to mail or fax the statement to HealthTeam Advantage.

The Dental Director or any person reviewing your claim will not be the same as, nor subordinate to, the person(s) who initially decided your claim. The reviewer will grant no deference to the prior decision about your claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the claim for the first time. The reviewer's decision will take into account all comments, documents,

records and other information relating to your claim even if the information was not available when your claim was initially decided.

The notice of any adverse determination regarding your appeal 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.

Adverse appeals will be automatically submitted to the CMS's contracted independent review entity within 60 calendar days from the date HealthTeam Advantage received the member's first level appeal. The Appeals Staff will concurrently notify the member that the appeal is being forwarded to CMS's independent review entity.

If you have a complaint or dispute, other than a Notice of Denial of Coverage, expressing dissatisfaction with the manner in which HealthTeam Advantage or a dentist has provided dental services, you can contact HealthTeam Advantage at the address listed above in this section or call customer service at 888-965-1965 within 60 days of the event. HealthTeam Advantage will respond in writing to all Grievances within 30 days of receipt.

Termination of Coverage

Your Delta Dental coverage may automatically terminate:

- When your Health Plan advises Delta Dental to terminate your coverage.
- On the first day of the month for which your Health Plan has failed to pay Delta Dental.
- For fraud or misrepresentation in the submission of any claim.
- For any other reason stated in the contract between Delta Dental and your Health Plan.

Delta Dental will not continue eligibility for any person covered under This Plan beyond the termination date requested by your Health Plan. A person whose eligibility is terminated may not continue coverage under this Member Handbook.

Delta Dental's obligation for payment of Benefits ends on the last day of coverage. This date is usually the first of the month following receipt of a valid, written request to disenroll that was accepted by your plan during a valid Medicare election period. However, Delta Dental will make payment for Covered Services provided on or before the last day of coverage, as long as Delta Dental receives a Claim for those services within one year of the date of service.

General Conditions

Subrogation and Right of Reimbursement

If Delta Dental provides Benefits under This Plan and you have a right to recover damages from another, Delta Dental is subrogated to that right.

To the extent that This Plan provides or pays Benefits for Covered Services, Delta Dental is subrogated to any right you or your Eligible Dependent has to recover from another, his or her insurer, or under his or her "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions. You or your legal representative must do whatever is necessary to enable Delta Dental to exercise its rights and do nothing to prejudice them.

If you recover 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 This Plan.

Obtaining and Releasing Information

While you are an Eligible Person, you agree to provide Delta Dental with any information it needs to process your claims and administer your Benefits. This includes allowing Delta Dental access to your dental records.

Dentist-Patient Relationship

Eligible Persons are free to choose any Dentist. Each Dentist maintains the dentist-patient relationship and is solely responsible to the patient for dental advice and treatment and any resulting liability.

Loss of Eligibility During Treatment

If an Eligible Person loses eligibility while receiving dental treatment, only Covered Services received while that person was covered under This Plan will be payable.

Certain services begun before the loss of eligibility may be covered if they are completed within 60 days from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. The difference between Delta Dental's payment and the total fee for those services is your responsibility.

Late Claims Submission

Delta Dental will make no payment for services or supplies if a claim for such has not been received by Delta Dental within one year following the date the services or supplies were completed.

Change of Member Handbook or Contract

No agent has the authority to change any provisions in this Member Handbook or the provisions of the contract on which it is based. No changes to this Member Handbook or the underlying contract are valid unless Delta Dental approves them in writing.

Actions

No action on a legal claim arising out of or related to this Member Handbook will be brought within 60 days after notice of the legal claim has been given to Delta Dental, unless prohibited by applicable state law. In addition, no action can be brought more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, if longer. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude you from seeking a judicial decision or pursuing other available legal remedies.

Right of Recovery Due to Fraud

If Delta Dental pays for services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a claim that contains false or misrepresented information, or pays a claim that is determined to be fraudulent due to your acts or acts of your Eligible Dependents, it may recover that payment from you or your Eligible Dependents. You and your Eligible Dependents authorize Delta Dental to recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you or your Eligible Dependents. Delta Dental will provide an explanation of the payment recovery at the time the deduction is made.

Governing Law

This Member Handbook and the underlying group contract will be governed by and interpreted under the Centers for Medicare and Medicaid Services (CMS)

Legally Mandated Benefits

If any applicable law requires broader coverage or more favorable treatment for you or your Eligible Dependents than is provided by this Member Handbook, that law shall control over the language of this Member Handbook.

Any person intending to deceive an insurer, who knowingly submits an application or files a claim containing a false or misleading statement, is guilty of insurance fraud.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call our toll-free hotline. We only accept anti-fraud calls at this number.

ANTI-FRAUD TOLL-FREE HOTLINE:

800.524.0147