Out-of-network liability and Balance Billing

For all Members:
"Balance billing" occurs when a provider bills an enrollee for charges other than the coinsurance, deductible or amounts that exceed the benefit maximum, if applicable.

If you obtain care from a *Non-Participating Dentist*, the Non-Participating Dentist may balance bill the member the difference between Delta Dental's Maximum Plan Allowance and his or her Billed Charges. This amount is in addition to applicable coinsurance, deductibles, amounts that exceed the benefit maximum (for adult participants only) and any non-covered services.

For Members in the Choice Plan:
If you obtain care from a *Participating Dentist*, (in the *Delta Dental Premier Network* or the *Delta Dental PPO Network*), the Participating Dentist will not balance bill the member. The Participating Dentist has agreed to accept Delta Dental's Maximum Plan Allowance (our allowed amount) as payment in full for covered services. Members are only responsible for applicable coinsurance, deductibles, amounts that exceed the benefit maximum (for adult participants only) and any non-covered services.

For Members in the Basic and Preferred Plans:
If you obtain care from a *PPO Participating Dentist*, the PPO Participating Dentist will not balance bill the member. The PPO Participating Dentist has agreed to accept Delta Dental's Maximum Plan Allowance for the Delta Dental PPO Program as payment in full for covered services. Members are only responsible for applicable coinsurance, deductibles, amounts that exceed the benefit maximum (for adult participants only) and any non-covered services.

If you obtain care from a Premier Participating Dentist, the Premier Participating Dentist may balance bill the member the difference between Delta Dental Plan's fee schedule for its Delta Dental Premier program and the fee schedule for its Delta Dental PPO program. This amount is in addition to applicable coinsurance, deductibles, amounts that exceed the benefit maximum (for adult participants only) and any non-covered services.

Claim Submission
If you obtain care from a Participating Dentist, (in the Delta Dental Premier Network or the Delta Dental PPO Network), the Participating Dentist will file your claims with Delta Dental on your behalf.

If you obtain care from a Non-Participating Dentist, the Non-Participating Dentist may file your claims with Delta Dental on your behalf. If the dentist does not file your claim on your behalf, you may contact Delta Dental's Customer Service at 866-991-7345 Monday – Friday, 7 a.m. – 5 p.m. Central Time to obtain a claim form or click here. You may also contact us via e-mail at service@deltadentalmo.com or by mail at P.O. Box 8690, St. Louis, MO 63126-0690.

Your claims must be filed by the end of the calendar year in which services were rendered. Delta Dental is not obligated to pay claims submitted after this period. Provided you advised the Participating Dentist of your eligibility for benefits at the time of treatment, you will not be liable to pay the Participating Dentist for the amount which would have been payable by Delta Dental if a claim is denied to the Participating Dentist's failure to submit a claim timely.

Grace Period

A *Grace Period* is a short period of time during which Delta Dental will not terminate your dental coverage even though you have not yet paid your outstanding dues or service charges (premiums). If you qualify for advance payments of the premium tax credits ("APTC") for your Delta Dental coverage and you have paid at least one full month's premium during the current plan year, you will have a 90 day grace period to pay your dues or service charges before your coverage will be terminated. During the first month of your grace period, Delta Dental will pay your claims for covered services. During the second and third months, Delta Dental will pend your claims. When a *claim is pending*, it means the claim was received by Delta Dental, but it has not yet been processed for payment. If you have not paid all of your outstanding dues or service charges by the end of the grace period, Delta Dental will terminate your coverage back to the end of the first month of your grace period.

Retroactive Denials

A retroactive denial is the reversal of a previously paid claim, where you then become responsible for payment of that claim. A claim will be retroactively denied if your premium payment for the month in which you received dental treatment does not settle due to insufficient funds or fails for any reason. Paying your premiums on time will reduce the risk of your claim retroactively denying.

A claim will be retroactively denied in whole or in part if the dental office informs Delta Dental they submitted a claim for services that were not rendered or they submitted incorrect treatment codes that caused benefits to be incorrectly calculated. If a claim was processed incorrectly causing an overpayment, a refund request will be issued to you or your provider and the recipient must pay Delta Dental the amount which was overpaid.

Enrollee Recoupment of Overpayment

If you make a premium overpayment because of an error in processing your eligibility or if a retroactive termination or cancelation is processed after your monthly or annual premium payment was received, you may be eligible for a premium overpayment. In most cases our billing system will recognize that a refund is due to you and a refund will be issued back through the payment method on file (e.g., if you pay your premiums via credit card, your overpayment will be refunded through the credit card on file). If you have questions regarding your premium payments you may contact us at 866-991-7345.

Medical Necessity, Prior Authorization and Predetermination

Medical necessity is used to describe care that is reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care. If you receive care that is not considered to be medically necessary, the claim for that care will be denied. Prior authorization is a process where some carriers require that you obtain their approval first before you obtain services under

the plan. Delta Dental does not require that you obtain prior authorization. *Predetermination of Benefits* is when a provider sends a treatment plan to Delta Dental for evaluation in advance of your care to determine how the claim will be covered under the plan. Predetermination is not required under the plan, but can be useful for larger claims to help you predict what your out-of-pocket costs will be.

Explanation of Benefits

An *explanation of benefits ("EOB")* is a statement Delta Dental will send you after you receive dental services to explain what dental treatment is paid for on your behalf Your EOB will show Delta Dental's payment (*Plan Pays*), and your financial responsibility (*Patient Pays*) under the terms of the policy. The EOB will give you information as to what services were completed by listing the procedure code, as well as the *procedure description*. It also gives you information regarding the charges and contracted fees (*Submitted Amount, Accepted Amount,* and *Allowed Amount*) as well as the amount of coverage provided by Delta Dental (*Co-Insurance Percent*). The *Adjustment Notice* listed next to the service line provides a code that refers to any additional comments. Those codes and corresponding comments are listed below the last service line. The EOBs will be sent out by Delta Dental after receiving and adjudicating your claims.

Coordination of Benefits

Coordination of benefits ("COB") exists when a member is also covered by another dental plan and determines which plan pays first. If you have other dental coverage, benefits under your Delta Dental plan are coordinated with benefits under your other dental plan to avoid duplicating payments. Generally, the plan that covers the subscriber will be primary and will pay before a plan that covers the individual as a dependent. If a child is covered under plans through both parents, generally, the parent's plan with an earlier birth date (month and date occur earlier in the calendar year) will be the primary plan (pay first) and the other plan will be secondary (pay next). The dental plans together will not pay more than 100% of the covered expenses.