



Delta Dental HMO

Certificate of Coverage

Lake Forest College

Group #10660
DeltaCare Plan 218
Effective Date: 06/01/09

DELTA DENTAL®

Delta Dental of Illinois

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SECTION I: INTRODUCTION

About This Booklet

This booklet contains a general description of your dental benefits plan for your use as a convenient reference. It reflects and is subject to the contract between Delta Dental and your employer or organization.

We encourage you to read this booklet to get the most out of your coverage. The more you understand your group dental plan, the more you will know what dental services are covered and what you may owe your *dentist.*

To help make the information easier to understand, we use the words "you" and "your" to refer to you and your family members eligible for coverage under this plan. "We, us and our" refer to Delta Dental of Illinois ("Delta Dental").

The definitions for the words that appear in *italics* on the following pages can be found in Section V, Definitions.

About Delta Dental

Delta Dental of Illinois is a not-for-profit dental service plan corporation. Our goal is to improve oral health by making dental care more affordable. Good oral health is essential to maintaining good general health and your dental benefits plan is designed to promote regular dental visits. Delta Dental is a member of Delta Dental Plans Association, the largest and most experienced dental benefits carrier system in the country.

Who Do I Contact for Assistance?

Many questions about your group dental plan can be answered by accessing our Web site at www.deltadentalil.com. Alternatively, our automated phone system is available 24 hours a day, seven days a week. (A touch-tone phone is required.) You can check claim status and obtain *dentist* referral information on the Web site or by using the automated phone system. Your questions may be answered most quickly by use of the Web site or automated phone system.

You also may contact us at 1-800-942-3772 to speak to a customer service representative for questions concerning eligibility, benefits information, status of your claim for *emergency services* or treatment from a *specialist*, or general information. Our customer service representatives are available Monday through Friday during our normal business hours. We also have a message center, available 24 hours a day, seven days a week, where you can leave a voice-mail message and have a customer service representative call you back the next business day. You can also e-mail customer service at CSI@deltadentalil.com.

SECTION II: HOW YOUR GROUP DENTAL PLAN WORKS

What You Should Know About Selecting a *Dentist*

May I go to any *dentist*?

As a DeltaCare *subscriber*, you will only receive benefits if the services or procedures are received by a *panel dentist*. Orthodontic services must be provided by a panel orthodontist.

When you enroll in the DeltaCare plan, you will receive a list of *panel dentists*. In order to receive *dental benefits* as a DeltaCare *subscriber* you must select, from the list provided, one primary care facility for yourself and your covered *dependents*. If the *panel dentist* you selected is unavailable, you will be asked to select another *panel dentist*. If you do not select a *panel dentist*, we may assign one to you.

Should a *panel dentist* cease to participate in the DeltaCare network, s/he is obligated to complete any service or procedure begun prior to his/her termination. In the event that said *panel dentist* fails to, or is unable to, complete the service or procedure, we may make reasonably and medically appropriate provisions for the completion of such service or procedure by another *dentist*.

May I select a different *panel dentist* for each member of my family?

No. Only one *panel dentist* may be chosen for you and your covered *dependents* (including covered *dependents* who are full-time students attending school in another area).

May I change to a different *panel dentist* outside of my employer's open enrollment period?

You may change to a different *panel dentist* at any time prior to the 21st day of any calendar month. Your new selection will become effective on the first day of the following calendar month.

What happens if I choose a *dentist* who does not participate in the DeltaCare network?

Delta Dental has no obligation or liability with respect to services or procedures rendered or performed by a non-*panel dentist* unless (a) all three of the following conditions are met: (1) the services or procedures are rendered by a *specialist;* (2) you are referred to the *specialist* by your *panel dentist*; and (3) Delta Dental authorizes in writing the services or procedures to be performed; OR (b) the services or procedures are *emergency services* as outlined herein.

How can I find out if my regular *dentist* is a participating *dentist* in the DeltaCare network, or get a list of *panel dentists* near me?

We offer two easy ways to locate a *panel dentist* 24 hours a day, 7 days a week. You can either:

- search our online *dentist* directory at www.deltadentalil.com or
- use the automated phone system by calling 1-800-942-3772.

Using either method, you can request a list of *panel dentists* within a designated area. We also advise that you check with your *dentist* to confirm whether s/he participates in the DeltaCare network.

What You Should Know About Referrals To A *Specialist*

Am I required to have a referral before receiving treatment from a *specialist*?

Your *panel dentist* may refer you to a *specialist* for certain treatment. Before you go to a *specialist*, your *panel dentist* must submit, in writing, a referral request to us.

* If you receive treatment from a *specialist* that is not authorized by Delta Dental, there is no guarantee of coverage. You may be responsible for the *specialist*'s entire billed fee.

What does a referral request need to include?

A referral request must be made by your *panel dentist* on a DeltaCare Specialty Referral Form. Certain procedures may require submission of x-rays or other supporting documentation by the *panel dentist* and/or pre-authorization by the *specialist*. Your *panel dentist* will prepare the referral request along with any required supporting documentation.

What happens after a referral request is submitted?

After the referral has been submitted, you may make an appointment with the *specialist*. For procedures requiring pre-authorization by the *specialist*, we will review the pre-authorization request within 15 days of receipt and advise whether the services and/or procedures to be performed are authorized to be performed by the *specialist*. A determination made by Delta Dental imposes no restrictions on the method of treatment by a *specialist* and only relates to the level of payment that we are required to make. Please see Appendix E, Appealing a Claim Denial, for a detailed explanation of claims and appeal procedures.

If you were referred to a *specialist* and the referral was approved in writing by us, you are only responsible for the designated *co-payment amount* listed in the Schedule of Dental Benefits. The *specialist* must submit a claim for payment for the referred treatment to us within 90 days after such treatment is rendered.

What You Should Know About *Emergency Services*

What happens if I require *emergency services*?

If you are more than 35 miles from your *panel dentist*'s office or if you are unable to see your *panel dentist* within 24 hours AND require *emergency services* (palliative treatment) as defined in this *certificate of coverage* (see page 10), you may go to any *dentist*. We will reimburse you for the cost of such treatment, less any applicable *co-payment amount*, up to the maximum benefit listed in the Dental Plan Specifications during any 12-month period. You must submit a claim to us within 90 days after treatment is rendered.

How do I file a claim for payment for *emergency services*?

You can complete a claim form and mail it to:

Delta Dental of Illinois
P.O. Box 3399
Lisle, IL 60532

The *dentist*'s statement and your proof of payment must accompany the claim.

You must file your own claim separately from another family member's claim.

If you need a claim form, you can ask your employer's benefits administrator for one or you can download one at www.deltadentalil.com.

Claims and Appeal Procedures

How will I know when a pre-authorization request for treatment from a *specialist* has been processed?

If the pre-authorization request involves urgent care, you and the *specialist* will be notified orally by telephone or in writing by facsimile, or by other similarly expeditious method appropriate to the circumstances, whether the plan has approved the referral.

For non-urgent pre-authorization requests, you and the *specialist* will be notified in writing whether the services are authorized to be performed by the *specialist*.

How will I know when my claim is processed?

For *specialist* claims, you will receive an Explanation of Benefits that describes the services your *dentist* submitted and the benefits that your group dental plan covers. The *specialist* will receive an Explanation of Payment along with the payment.

For *emergency services* claims, along with your payment you will receive an Explanation of Payment that describes the services your *dentist* submitted and the benefits that your group dental plan covers.

How do I appeal a denied pre-authorization request or claim?

You may request an expedited review of a denial of a pre-authorization request for urgent care by a *specialist* by contacting us by telephone or in writing by facsimile or by other similarly expeditious method.

You may appeal a non-urgent pre-authorization request or claim that is denied in whole or in part by written request within 180 days from the date of the denial notice. Send your written request for review to:

Reevaluation Committee
Delta Dental of Illinois
801 Ogden Ave.
Lisle, IL 60532

If you have any additional documents or records in support of your appeal, they should accompany your written request for review.

See Appendix E for a detailed explanation of the provisions governing claims and appeal procedures under your group dental plan.

SECTION III: YOUR COVERED SERVICES AND DENTAL BENEFITS

What services are covered under this group dental plan?

Attached to this booklet is a list of the dental procedures for which you have coverage. See Appendix A -- Schedule of Dental Benefits -- for the list of dental procedures covered under your group dental plan.

Periodically, we are required to update the dental procedure codes and descriptions listed in the Schedule of Dental Benefits. For this reason, we strongly recommend that you review an up-to-date copy of the Schedule of Dental Benefits prior to receiving treatment from your *panel dentist*. A current version of the complete Schedule of Dental Benefits for your group dental plan is available by:

- accessing the Subscriber Connection on our Web site;
- using the automated phone system; or
- speaking with a customer service representative.

What services are not covered under this plan?

Not all services that your *panel dentist* performs may be covered under your group dental plan. See Appendix B for a list of services that are not covered (excluded from coverage).

Are covered procedures subject to any contract limitations or payment policies?

Yes, your employer or organization has contracted with Delta Dental to apply certain contract limitations or payment policies for the procedures covered under your group dental plan. For example, there are frequency limitations associated with certain procedures such as teeth cleaning. More frequent teeth cleaning is not a benefit even if your *panel dentist* states that it is dentally necessary and dentally appropriate. This does not mean that Delta Dental considers more frequent cleanings dentally unnecessary or dentally inappropriate; rather, this is simply a limitation on how often benefits are allowed for cleanings under your group dental plan. When benefits are not allowed for a dental service or procedure due to a contract limitation or payment policy, you will be responsible for the *dentist's* billed fee for that service or procedure. See Appendix A, Schedule of Dental Benefits, for the applicable payment policies.

What is an optional treatment provision and how does it work?

There are times when multiple ways may be available to treat a dental condition. The payment policies may cover only one way. This does not mean that your *panel dentist* made an inappropriate recommendation but you may have higher out-of-pocket expenses if you choose a treatment that costs more.

For example, your *panel dentist* places a resin-based composite (tooth colored filling) on a molar. Under your group dental plan, the posterior resin-based composite is considered optional treatment.

Coverage is limited to the *dental benefit* provided under your group dental plan, in this case the benefit for an amalgam (silver filling). You are responsible for the difference in cost between the *panel dentist*'s billed fee for the covered service and the *panel dentist*'s billed fee for the optional (or more expensive) treatment, plus any applicable *co-payment amount* for the covered service.

Panel dentist's billed fee for a posterior resin-based composite	$90.00
Panel dentist's billed fee for an amalgam	$65.00
Listed *co-payment amount* for amalgam	$13.00

In this particular example, the patient's out-of-pocket cost is $38.00.

What amounts do I have to pay under this group dental plan?

Provided the dental services and procedures performed are covered and are rendered by a *panel dentist* or by a *specialist* for an approved referral, you are only responsible for paying the designated *co-payment amount* listed in the Schedule of Dental Benefits.* If the dental services and procedures performed are not covered under this group dental plan, you are responsible for paying the *dentist*'s billed fee for those services and procedures.

* Subject to the optional treatment provision stated in this certificate.

What is coordination of benefits?

Coordination of benefits happens when you are covered under more than one policy or prepaid health care plan.

For services rendered by a panel dentist or panel orthodontist, the benefits under this group dental plan always are paid as primary; that is, its benefits are determined without considering any other plan's benefits.

For services rendered by a *specialist,* if this plan is the secondary plan, we will determine what benefits would have been paid if the patient didn't have other coverage. We will then pay the balance of the *approved amount* (the amount the *specialist* has agreed to accept as full payment under the DeltaCare program) that was not paid by the primary plan, up to what Delta Dental's payment would have been if the patient had no other coverage.

The combined payments of all plans will never be more than the patient's actual bill.

See Appendix D for the Coordination of Benefits rules governing your group dental plan.

Who do I submit my claim to first in a situation where coordination of benefits applies?

Submit the claim to the primary plan first. When you receive payment from that plan, submit the claim and a copy of the primary plan's Explanation of Benefits to the secondary plan.

SECTION IV: ENROLLMENT AND CHANGES TO ENROLLMENT

Who is eligible to enroll in this group dental plan?

You and your *dependents* are eligible for coverage under this group dental plan beginning on the first day your group dental plan becomes effective or as determined by your employer's or organization's eligibility requirements.

An adopted child is eligible from the first of the month following the date the child is adopted or placed for adoption or the first of the month following the date of a final order granting adoption, whichever comes first.

Individuals in military service are not eligible. If you are called to active duty while in the Reserve or National Guard, your coverage (and that of your eligible *dependents*, if applicable) will terminate on the last day of the month in which you depart for active duty. This termination policy will also apply to an eligible *dependent* who is called to active duty. Upon return to civilian status, you (and your eligible *dependents,* if applicable) will be reinstated with coverage on the first of the month following the date you return to work. An eligible *dependent* who returns to civilian status will be reinstated on the first of the month following the date active military status ceases.

To what age is my dependent child covered?

See Appendix C – Dental Plan Specifications -- for dependent child age limitations.

Will I be asked to verify that my child is a full-time student in an accredited school, college or university?

No. Unmarried dependent children under age 26 are eligible for coverage regardless of student status.

Is the limiting age extended for disabled *dependents*?

Yes, your unmarried child may continue to be eligible as a *dependent* if incapable of self-support because of physical or mental incapacity (that began prior to losing *dependent* status or prior to the date of your eligibility). Your unmarried child must also be chiefly dependent on you for support. We require you to submit proof of the incapacity and dependency within 31 days after we make such a request and subsequently as we may require, but not more frequently than annually.

When may I elect coverage?

You may elect to enroll in this group dental plan within 30 days following the satisfaction of the eligibility requirements or during an open enrollment period. At this time, you may also elect to enroll your eligible *dependents,* if such coverage is offered.

For information about the initial 90-day enrollment period for dependent children eligible under Illinois Public Act 95-0958 (the Young Adult Dependent Age Law), see below for the amendment to Appendix C, Dental Plan Specifications

When can I make a change in coverage election(s)?

You may change the type of coverage elected during the *benefit period* if there is a qualifying status change and a written request and proof of said change is provided within 60 days of the date of the change.

What is a qualifying status change?

Qualifying status changes include the following:

- Changes in family status, to include ONLY: change in your legal marital status; change in the number of *dependents*; or a *dependent*'s satisfying (or no longer satisfying) *dependent* eligibility requirements.

- Taking or returning from a leave of absence under the Family and Medical Leave Act of 1993 (FMLA) or a military leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

A newborn infant will be covered from the moment of birth for 31 days. A newborn infant is a child under 31 days of age. You must notify us within 60 days of the date of birth in order to have the coverage continue beyond the 31-day period. Additional premium may be required if you are not already enrolled with the appropriate *family coverage*. When additional premium is required, payment of applicable premium will be for the period from the date of birth and will be due on the first premium due date after the birth of the newborn infant.

Coverage is provided under this group dental plan for congenital defects in newborn infants only.

May I discontinue coverage during or at the end of a *benefit period*?

Once enrolled in this group dental plan, you and your *dependents* must remain enrolled for the duration of the *benefit period* unless there is a qualifying status change. If coverage is terminated, you or your *dependents* will not be permitted to re-enroll until an open enrollment period occurring at least 24 months after the date of termination.

When does coverage terminate?

Your (and/or, if applicable, your *dependent*'s) coverage may be terminated:

- when your employer or organization advises us to terminate coverage;
- when your employer or organization fails to pay us the required premiums;
- when this group dental plan is terminated;
- when you no longer meet the eligibility requirements for coverage;
- when you knowingly commit or permit another person to commit fraud or deception in obtaining *dental benefits* under this group dental plan; or
- when your dependent child has reached the limiting age for *dependent* coverage, unless the dependent child meets the criteria for disabled *dependent* coverage.

Should your and/or any of your *dependent*'s coverage terminate under this group dental plan, the *panel dentist* is obligated to complete any service or procedure started while coverage was in effect. In the event that said *panel dentist* fails to, or is unable to, complete the service or procedure, we may make reasonable and appropriate provisions for the completion of such service or procedure by another *dentist*.

* Please note that Delta Dental does not offer the option of conversion to an individual policy.

What is continuation of coverage?

Federal law (Consolidated Omnibus Budget Reconciliation Act of 1985, known as COBRA) may allow you and/or your eligible *dependents* to elect to continue coverage that would otherwise end as a result of certain events. You may also be eligible to continue coverage under Illinois law, even if your employer or organization is not governed by COBRA.

See Appendix F for the provisions governing continuation of coverage under federal and state law

DEFINITIONS

"Benefit Period" means the reference period specified in the Dental Plan Specifications for purposes of determining when enrollment changes are permitted.

"Certificate of Coverage" means the subscription certificate issued to a *subscriber* by Delta Dental setting forth the terms and conditions of this group dental plan. The *group subscriber* shall be responsible for distributing copies of the *certificate of coverage* to *subscribers*.

"Co-Payment Amount" means the amount that a *covered individual* must pay for a particular covered service under this group dental plan as set forth in the Schedule of Dental Benefits.

"Covered Individual" means any *subscriber* or any *dependent* of that *subscriber* for whom coverage becomes effective and for whom premiums are paid, unless and until coverage terminates as provided in this *certificate of coverage*.

"Date of Service" means the date treatment is COMPLETED for any particular covered service for the purpose of allocating the *dental benefit* for that service to the appropriate *benefit period* and paying claims made under this group dental plan.

"Dental Benefits" means benefits paid for those dental procedures or services covered under this group dental plan and subject to the exclusions, terms and conditions contained in this *certificate of coverage*.

"Dentist" means a *dentist* licensed to practice dentistry at the time and in the place services are provided.

"Dependent" means the *subscriber's* spouse under federal law and eligible unmarried children (including stepchildren, adopted children, children placed for adoption with the *subscriber*, foster children, and children for whom the *subscriber* is a legal guardianand children of a Domestic Partner). For age limitations and other eligibility requirements for dependent children, see the Dental Plan Specifications.

"Domestic Partner" means an individual of the same or opposite gender of the Subscriber in which meets the Subscriber has completed a signed Affidavit of Domestic Parthership and Tax Certification of Dependency form if applicable, and with whom the Subscriber is in a relationship which meets the following criteria:

(a) Have lived together and have been each other's sole Domestic Partner for at least six (6) months;
(b) Are not married to anyone else nor have another Domestic Partner;
(c) Are at least 18 years of age and mentally competent to consent to contract;
(d) Reside together in the same regular and permanent residence and intend to do so indefinetely;
(e) Have an exclusive mutual commitment similar to that of marriage;
(f) Are not related by blood closer than would bar marriage in the state of one's legal residence;
(g) Are jointly responsible for each other's common welfare and share financial obligations and can provide all or some of the types of documentation indicated below, if requested:

- Domestic Partner Affidavit
- Joint mortgage, lease or deed
- Designation of Domestic Partner as primary beneficiary in for life insurance and retirement contract
- Designation of Domestic Partner as primary beneficiary in employee's or insured's will
- Durable property and health care powers of attorney
- Joint ownership of motor vehicle, joint checking account or joint credit account.

"Emergency Services" means only those palliative dental services immediately required for the alleviation of severe pain, swelling or bleeding, to avoid serious impairment to the dentition or placing the patient's oral health in serious jeopardy.

"Family Coverage" means coverage for a *subscriber* plus a spouse and/or one or more dependent children.

"Group Subscriber" means that particular employing individual, agency, corporation, partnership, or company, or that particular association or trust which has entered into this agreement to provide dental coverage to its eligible employees or members. The *group subscriber* is responsible for appointing a *plan administrator* for the group dental plan.

"Panel Dentist" means a *dentist* who, by written agreement with Delta Dental, has agreed to participate in the DeltaCare program and to provide to *covered individuals* those services or procedures which are covered under this group dental plan. Panel Dentists are solely responsible for their treatment decisions and the dental services they provide to *covered individuals;* they are not agents or employees of Delta Dental.

"Plan Administrator" means the *group subscriber* (or the individual(s) designated by the *group subscriber*) who maintains the welfare benefit plan under which these *dental benefits* are provided.

"Specialist" means a *dentist* who specializes in a particular type of dental care (i.e., oral surgery, endodontics or periodontics) and who, by written agreement with Delta Dental, has agreed to participate in the DeltaCare program and to provide to *covered individuals* those services or procedures which are covered under this group dental plan. *Specialists* are solely responsible for their treatment decisions and the dental services they provide to *covered individuals;* they are not employees or agents of Delta Dental.

"Subscriber" means an employee or member of *group subscriber*, as provided herein, who is eligible under and enrolls in this group dental plan.

For defined dental terms, log on to www.deltadentalil.com and select Oral Health.

APPENDIX A
DESCRIPTION OF BENEFITS AND COPAYMENTS

CODES		PATIENT COPAYMENT
	(D0100-D0999) DIAGNOSTIC	
	Office visit, per visit (in addition to other services)	No Cost
D0120	Periodic oral evaluation	No Cost
D0140	Limited oral evaluation - problem focused	No Cost (GP)/$30.00 (SP)
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (Established patient; not post-operative visit)	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0210	Intraoral radiographs - complete series (including bitewings)	No Cost
D0220	Intraoral - periapical first film	No Cost
D0230	Intraoral - periapical each additional film	No Cost
D0240	Intraoral - occlusal film	No Cost
D0270	Bitewing - single film	No Cost
D0272	Bitewings - two films	No Cost
D0274	Bitewings - four films	No Cost
D0277	Vertical bitewings - 7 to 8 films	No Cost
D0330	Panoramic film	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost

Bitewing x-rays are limited to not more than one series of four films in any six month period.

Full mouth x-rays are limited to one set every 24 consecutive months.

	(D1000-D1999) PREVENTIVE	
D1110	Prophylaxis (cleaning) - adult - 1 per 6 month period	No Cost
D1120	Prophylaxis (cleaning) - child - 1 per 6 month period	No Cost
D1201	Topical application of fluoride (including prophylaxis) - child (to age 19) - 1 per 6 month period	No Cost
D1203	Topical application of fluoride (prophylaxis not included) - child (to age 19) - 1 per 6 month period	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth	$10.00
D1510	Space maintainer - fixed - unilateral	$40.00
D1515	Space maintainer - fixed - bilateral	$40.00
D1520	Space maintainer - removable - unilateral	$40.00
D1525	Space maintainer - removable - bilateral	$40.00
D1550	Recementation of space maintainer	$10.00

Prophylaxis is limited to one treatment each six-month period (includes periodontal maintenance following active therapy).

Sealant benefits include the application of sealants only to the occlusal surface of permanent molars for patients through age 15. The teeth must be free from caries or restorations on the occlusal surface.

Sealant benefits include the repair or replacement of a sealant on any tooth within three years of its application by the same Panel Dentist who placed the sealant.

CODES		PATIENT COPAYMENT
	(D2000-D2999) RESTORATIVE (Fillings and single crowns) (Includes indirect pulp capping, bases, liners and acid etch procedures)	
D2140	Amalgam - one surface, primary or permanent	$4.00
D2150	Amalgam - two surfaces, primary or permanent	$7.00
D2160	Amalgam - three surfaces, primary or permanent	$10.00
D2161	Amalgam - four or more surfaces, primary or permanent	$12.00
D2330	Resin-based composite - one surface, anterior	$10.00
D2331	Resin-based composite - two surfaces, anterior	$15.00
D2332	Resin-based composite - three surfaces, anterior	$20.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$30.00
D2390	Resin-based composite crown, anterior	$50.00
D2391	Resin-based composite - one surface, posterior	Optional
D2392	Resin-based composite - two surfaces, posterior	Optional
D2393	Resin-based composite - three surfaces, posterior	Optional
D2394	Resin-based composite - four or more surfaces, posterior	Optional
D2410	Gold foil - one surface	Optional
D2420	Gold foil - two surfaces	Optional
D2430	Gold foil - three surfaces	Optional
D2510	Inlay - metallic - one surface*	Optional
D2520	Inlay - metallic - two surfaces*	Optional
D2530	Inlay - metallic - three or more surfaces*	Optional
D2542	Onlay - metallic - two surfaces*	Optional
D2543	Onlay - metallic - three surfaces*	Optional
D2544	Onlay - metallic - four or more surfaces*	Optional
D2610	Inlay - porcelain/ceramic - one surface	Optional
D2620	Inlay - porcelain/ceramic - two surfaces	Optional
D2630	Inlay - porcelain/ceramic - three or more surfaces	Optional
D2642	Onlay - porcelain/ceramic - two surfaces	Optional
D2643	Onlay - porcelain/ceramic - three surfaces	Optional
D2644	Onlay - porcelain/ceramic - four or more surfaces	Optional
D2650	Inlay - resin-based composite - one surface	Optional
D2651	Inlay - resin-based composite - two surfaces	Optional
D2652	Inlay - resin-based composite - three or more surfaces	Optional
D2662	Onlay - resin-based composite - two surfaces	Optional
D2663	Onlay - resin-based composite - three surfaces	Optional
D2664	Onlay - resin-based composite - four or more surfaces	Optional
D2710	Crown - resin-based composite (indirect)†	$50.00
D2720	Crown - resin with high noble metal*†	$180.00
D2721	Crown - resin with predominantly base metal†	$180.00
D2722	Crown - resin with noble metal†	$180.00
D2740	Crown - porcelain/ceramic substrate†	$180.00
D2750	Crown - porcelain fused to high noble metal*†	$180.00
D2751	Crown - porcelain fused to predominantly base metal†	$180.00
D2752	Crown - porcelain fused to noble metal†	$180.00
D2780	Crown - ¾ cast high noble metal*	$180.00
D2781	Crown - ¾ cast predominantly base metal	$180.00
D2782	Crown - ¾ cast noble metal	$180.00
D2783	Crown - ¾ porcelain/ceramic†	$180.00
D2790	Crown - full cast high noble metal*	$180.00
D2791	Crown - full cast predominantly base metal	$180.00
D2792	Crown - full cast noble metal	$180.00
D2794	Crown - titanium*	$180.00
D2910	Recement inlay, onlay or partial coverage restoration	$10.00
D2915	Recement cast or prefabricated post and core	$10.00

CODES		PATIENT COPAYMENT
D2920	Recement crown	$10.00
D2930	Prefabricated stainless steel crown - primary tooth	$35.00
D2931	Prefabricated stainless steel crown - permanent tooth	$35.00
D2932	Prefabricated resin crown (anterior teeth only)	$35.00
D2933	Prefabricated stainless steel crown with resin window	Optional
D2940	Sedative filling	$5.00
D2950	Core buildup, including any pins	$15.00
D2951	Pin retention - per tooth, in addition to restoration	$15.00
D2952	Cast post and core in addition to crown*	$15.00
D2953	Each additional cast post - same tooth*	$15.00
D2954	Prefabricated post and core in addition to crown	$15.00
D2957	Each additional prefabricated post - same tooth	$15.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$36.00
D2980	Crown repair, by report	$20 + lab

Composite resin restorations to restore decay or missing tooth structure that extend beyond the enamel layer are limited to anterior teeth (cuspid to cuspid) and facial surfaces of maxillary bicuspids.

Crown(s) and bridges are not to be replaced within any five-year period from initial placement.

(D3000-D3999) ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	$5.00
D3120	Pulp cap - indirect (excluding final restoration)	$5.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$5.00
D3221	Pulpal debridement, primary and permanent teeth	$5.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$5.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$5.00
D3310	Root canal - anterior (excluding final restoration)	55.00
D3320	Root canal - bicuspid (excluding final restoration)	$110.00
D3330	Root canal - molar (excluding final restoration)	$165.00
D3346	Retreatment of previous root canal therapy - anterior	$55.00
D3347	Retreatment of previous root canal therapy - bicuspid	$110.00
D3348	Retreatment of previous root canal therapy - molar	$165.00
D3410	Apicoectomy/periradicular surgery - anterior	$85.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$85.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	$85.00
D3426	Apicoectomy/periradicular surgery (each additional root)	$85.00
D3430	Retrograde filling - per root	$50.00

(D4000-D4999) PERIODONTICS
(Includes preoperative and postoperative evaluations and treatment under local anesthetic)

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces, per quadrant	$150.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces, per quadrant	$150.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces, per quadrant	$135.00

CODES		PATIENT COPAYMENT
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces, per quadrant	$135.00
D4245	Apically positioned flap	$135.00
D4249	Clinical crown lengthening - hard tissue	$175.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces, per quadrant	$275.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces, per quadrant	$275.00
D4341	Periodontal scaling and root planing - four or more teeth, per quadrant	$40.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	$40.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$40.00
D4910	Periodontal maintenance (following active therapy)	$32.00

Periodontal treatments (root planing/subgingival curettage) are limited to four quadrants during any 12 consecutive months.

Full mouth debridement (gross scale) is limited to one treatment in any 12 consecutive month period.

(D5000-D5899) PROSTHODONTICS (removable)

D5110	Complete denture - maxillary**	$225.00
D5120	Complete denture - mandibular**	$225.00
D5130	Immediate denture - maxillary**	$300.00
D5140	Immediate denture - mandibular**	$300.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)**	$275.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)**	$275.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)**	$275.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)**	$275.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)**	Optional
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)**	Optional
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$250.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5510	Repair broken complete denture base	$25.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$25.00
D5610	Repair resin denture base	$25.00
D5620	Repair cast framework	$25.00
D5630	Repair or replace broken clasp	$25.00
D5640	Replace broken teeth - per tooth	$25.00
D5650	Add tooth to existing partial denture	$10.00
D5660	Add clasp to existing partial denture	$10.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$150.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$150.00
D5710	Rebase complete maxillary denture	$50.00
D5711	Rebase complete mandibular denture	$50.00

CODES		PATIENT COPAYMENT
D5720	Rebase maxillary partial denture	$50.00
D5721	Rebase mandibular partial denture	$50.00
D5730	Reline complete maxillary denture (chairside)	$30.00
D5731	Reline complete mandibular denture (chairside)	$30.00
D5740	Reline maxillary partial denture (chairside)	$30.00
D5741	Reline mandibular partial denture (chairside)	$30.00
D5750	Reline complete maxillary denture (laboratory)	$50.00
D5751	Reline complete mandibular denture (laboratory)	$50.00
D5760	Reline maxillary partial denture (laboratory)	$50.00
D5761	Reline mandibular partial denture (laboratory)	$50.00
D5820	Interim partial denture (maxillary)	No Cost
D5821	Interim partial denture (mandibular)	No Cost
D5850	Tissue conditioning, maxillary	$10.00
D5851	Tissue conditioning, mandibular	$10.00
D5860	Overdenture - complete, by report	Optional
D5861	Overdenture - partial, by report	Optional

**includes any adjustment for six months

(D5900-D5999) MAXILLOFACIAL PROSTHETICS - Not Covered

(D6000-D6199) IMPLANT SERVICES - Not Covered

(D6200-D6999) PROSTHODONTICS (fixed)
(each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])

D6210	Pontic - cast high noble metal*	$180.00
D6211	Pontic - cast predominantly base metal	$180.00
D6212	Pontic - cast noble metal	$180.00
D6240	Pontic - porcelain fused to high noble metal*†	$180.00
D6241	Pontic - porcelain fused to predominantly base metal†	$180.00
D6242	Pontic - porcelain fused to noble metal†	$180.00
D6250	Pontic - resin with high noble metal*†	$180.00
D6251	Pontic - resin with predominantly base metal†	$180.00
D6252	Pontic - resin with noble metal†	$180.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis	Optional
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Optional
D6600	Inlay - porcelain/ceramic, two surfaces	Optional
D6601	Inlay - porcelain/ceramic, three or more surfaces	Optional
D6602	Inlay - cast high noble metal, two surfaces*	Optional
D6603	Inlay - cast high noble metal, three or more surfaces*	Optional
D6604	Inlay - cast predominantly base metal, two surfaces	Optional
D6605	Inlay - cast predominantly base metal, three or more surfaces	Optional
D6606	Inlay - cast noble metal, two surfaces	Optional
D6607	Inlay - cast noble metal, three or more surfaces	Optional
D6608	Onlay - porcelain/ceramic, two surfaces	Optional
D6609	Onlay - porcelain/ceramic, three or more surfaces	Optional
D6610	Onlay - cast high noble metal, two surfaces*	Optional
D6611	Onlay - cast high noble metal, three or more surfaces*	Optional
D6612	Onlay - cast predominantly base metal, two surfaces	Optional
D6613	Onlay - cast predominantly base metal, three or more surfaces	Optional
D6614	Onlay - cast noble metal, two surfaces	Optional
D6615	Onlay - cast noble metal, three or more surfaces	Optional
D6720	Crown - resin with high noble metal*†	$180.00
D6721	Crown - resin with predominantly base metal†	$180.00
D6722	Crown - resin with noble metal†	$180.00

CODES		PATIENT COPAYMENT
D6750	Crown - porcelain fused to high noble metal*†	$180.00
D6751	Crown - porcelain fused to predominantly base metal†	$180.00
D6752	Crown - porcelain fused to noble metal†	$180.00
D6780	Crown - ¾ cast high noble metal*	$180.00
D6781	Crown - ¾ cast predominantly base metal	$180.00
D6782	Crown - ¾ cast noble metal	$180.00
D6790	Crown - full cast high noble metal*	$180.00
D6791	Crown - full cast predominantly base metal	$180.00
D6792	Crown - full cast noble metal	$180.00
D6930	Recement fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6970	Cast post and core in addition to fixed partial denture retainer*	$25.00
D6971	Cast post as part of fixed partial denture retainer*	$25.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$15.00
D6973	Core build up for retainer, including any pins	Not Covered
D6976	Each additional cast post - same tooth*	$25.00
D6977	Each additional prefabricated post - same tooth	$15.00

* Base or noble metal is the benefit. If high noble metal (precious) is used for a crown, bridge, cast post and core, inlay or onlay, the Enrollee will be charged the additional laboratory cost of the high noble metal. An additional laboratory charge also applies to a titanium crown.

† Porcelain on molars is considered optional treatment.

Full maxillary and/or mandibular dentures including immediate dentures are not to exceed one each in any five-year period from initial placement.

Partial dentures are not to be replaced within any five-year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.

Crown(s) and bridges are not to be replaced within any five-year period from initial placement.

Denture relines are limited to one per denture during any 12 consecutive months.

Replacement of prosthetic appliances (bridges, partial or full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five-year limitation for replacement.

A fixed bridge is limited to the replacement of permanent anterior teeth provided it is not in connection with a partial denture on the same arch, or duplicates an existing, non-functional bridge and it meets the five-year limitation for replacement.

Stayplates, in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period or in children 16 years and under for missing anterior teeth.

CODES		PATIENT COPAYMENT
	(D7000-D7999) ORAL AND MAXILLOFACIAL SURGERY (Includes preoperative and postoperative evaluations and treatment under local anesthetic)	
D7111	Extraction, coronal remnants - deciduous tooth	$6.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal); includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary	$6.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth, minor smoothing of socket bone and closure	$10.00
D7220	Removal of impacted tooth - soft tissue	$50.00
D7230	Removal of impacted tooth - partially bony	$70.00
D7240	Removal of impacted tooth - completely bony	$90.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$90.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$10.00
D7286	Biopsy of oral tissue - soft (all others)	$20.00
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
D7471	Removal of lateral exostosis (maxilla or mandible)	$50.00
D7472	Removal of torus palatinus	$50.00
D7473	Removal of torus mandibularis	$50.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	No Cost
	(D9000-D9999) ADJUNCTIVE GENERAL SERVICES	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia	No Cost
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$20.00
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9999	Unspecified adjunctive procedure, by report - *includes failed appointment without 24 hour notice, per 15 minutes of appointment time*	$10.00

CODES		PATIENT COPAYMENT
	(D8000-D8999) ORTHODONTICS	
	Services solely for the purposes of Orthodontia would be covered in the following manner:	
D8660	Pre-orthodontic treatment visit *(applied to treatment fee if patient proceeds with treatment)*	$25.00
	Records (pre-treatment)	$200.00
	Includes:	
D0210	Intraoral - complete series (including bitewings)	
D0322	Tomographic survey	
D0330	Panoramic film	
D0340	Cephalometric film	
D0350	Oral/facial photographic images	
D0470	Diagnostic casts	
	Records (post-treatment)	$70.00
	Includes:	
D0210	Intraoral - complete series (including bitewings)	
D0470	Diagnostic casts	
D8020	Limited orthodontic treatment of the transitional dentition ***	$1950.00
D8030	Limited orthodontic treatment of the adolescent dentition ***	$1950.00
D8040	Limited orthodontic treatment of the adult dentition ***	$2150.00
D8070	Comprehensive orthodontic treatment of the transitional dentition ***	$1950.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition ***	$1950.00
D8090	Comprehensive orthodontic treatment of the adult dentition ***	$2150.00
D8670	Periodic orthodontic treatment visit (as part of contract)	Included in total case fee
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) ***	No Cost

*** Services include initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of 24 months.

For treatment plans extending beyond 24 months of active treatment, the patient will be subject to a monthly office visit fee not to exceed $75.00 per month.

The program provides coverage discounts on fees for orthodontic treatment plans provided through DeltaCare panel orthodontists. The start-up fees and the cost to the Enrollee for the treatment plan are listed above, subject to the following:

Orthodontic treatment must be provided by a DeltaCare orthodontist.

Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee and not DeltaCare will be responsible for payment of the balance due for treatment provided after cancellation or termination. In such a case the Enrollee's payment shall be based on the provider's submitted fee at the beginning of treatment. The amount will be pro-rated over the number of months to completion of the treatment and, will be payable by the Enrollee on such terms and conditions as are arranged between the Enrollee and the orthodontist.

If treatment is not required or the Enrollee chooses not to start treatment after the diagnosis and consultation have been completed by the orthodontist, the Enrollee will be charged a consultation fee of $25.00 in addition to diagnostic record fees.

Three (3) recementations or replacements of a bracket/band on the same tooth or a total of five (5) rebracketings/rebandings on different teeth during the covered course of treatment are a benefit. If any additional recementations or replacements of brackets/bands are performed, the patient is responsible for the cost at the dentist's usual and customary fee.

Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the patient's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the DeltaCare orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same copayment amount as for fixed appliances.

GENERAL LIMITATIONS

Any procedure not listed in this Schedule may be available from a Panel Dentist on a fee-for-service basis, with the Panel Dentist's usual fee to be charged to the Enrollee. "Usual fee" is the fee which the Panel Dentist most frequently charges to and collects from uninsured patients. "Uninsured" means not covered by a government program or private group plan. The Enrollee should ask the Panel Dentist who will perform a procedure that is not listed and what the Panel Dentist's usual fee is for that procedure in advance of receiving the services.

In the case of dental services not listed, Panel Dentist agrees to inform the Enrollee in advance of providing any such treatment, that such services are not covered, that the Enrollee is responsible for payment, and the usual fee for such services as a condition precedent to charging the Enrollee for such services.

If services for a listed procedure are performed by the assigned Panel Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide specialized services, and are referred by the assigned Panel Dentist, must be prior authorized in writing by the Plan Administrator. The Enrollee pays the Copayment specified for such services.

The above procedures are performed as needed and deemed necessary by your attending Panel Dentist subject to the Limitations and Exclusions of the Program.

The Panel Dentist shall provide emergency palliative dental care which is required while an Enrollee is within 35 miles of the office of the Panel Dentist. If an Enrollee is more than 35 miles from the office of the assigned Panel Dentist or is unable to see the Panel Dentist within 24 hours AND requires palliative treatment for emergency services, the Plan shall reimburse the Enrollee for the cost of such treatment, less any applicable co-payment amount, up to a maximum of $50 during any 12-month calendar year. Emergency dental care shall be limited to listed procedures, and as described in code 9110 above: "Palliative (emergency) treatment of dental pain." Any further treatment of the cause of such emergency dental care must be pre-authorized from the Plan or provided by the assigned Panel Dentist.

Coverage is limited to the benefit customarily provided. Patient must pay the difference in cost between the dentist's usual fees for the covered benefit and the optional or more expensive treatment plus any applicable copayment.

Services that are more expensive than the treatment usually provided under accepted dental practice standards or include the use of specialized techniques instead of standard procedures, such as a crown where filling would restore a tooth or an implant in place of a fixed bridge or partial to restore a missing tooth, are considered optional treatment.

Pedodontic benefits are limited to children under age four upon prior authorization by DeltaCare at 100% of the Dentist's submitted fee less applicable copayments. For children age four and over, upon prior authorization by DeltaCare, the Plan will provide a discount of 50% off the Dentist's submitted fee, less applicable copayments, for pedodontic services.

APPENDIX B
EXCLUSIONS OF BENEFITS

1) General anesthesia, IV sedation, and nitrous oxide and the services of a special anesthesiologist.

2) Dental procedures performed for purely cosmetic purposes.

3) Dental conditions arising out of and due to Enrollee's employment for which Worker's Compensation is payable. Services which are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision.

4) Treatment required by reason of war, declared or undeclared.

5) Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a dentist for treatment in any such facility.

6) Treatment of fractures, dislocations and subluxations of the mandible or maxilla. This includes any surgical treatment to correct facial mal-alignments or TMJ abnormalities.

7) Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures).

8) Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage or dental expenses incurred in connection with any dental procedure started prior to Enrollee's eligibility with the DeltaCare program. Examples: teeth prepared for crowns, root canals in progress, orthodontic treatment.

9) Any service that is not specifically listed as a covered expense.

10) Correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function. This exclusion does not apply to newly born children.

11) Cysts and malignancies.

12) Prescription drugs.

13) Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.

14) Cases in which, in the professional judgment of the attending Dentist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded.

15) Dental services received from any dental office other than the assigned dental office, unless expressly authorized in writing by DeltaCare or as cited under “Emergency Treatment.”

16) Prophylactic removal of impactions (asymptomatic, nonpathological).

17) Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.

18) “Consultations” for noncovered benefits.

19) Placement of a crown where there is sufficient tooth structure to retain a standard filling.

20) Porcelain crowns and porcelain fused to metal crowns on all molars.

21) Restorations placed due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.

22) Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered optional dental treatment. The patient must pay the difference in cost between the Dentist’s usual fees for the covered benefit and optional treatment, plus any coinsurance for the covered benefit.

23) Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ).

24) Extensive treatment plans involving 10 or more crowns or units of fixed bridgework (major mouth reconstruction).

25) Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization.

26) Soft tissue management (irrigation, infusion, special toothbrush).

27) Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

28) Restorative work caused by orthodontic treatment.

29) Extractions solely for the purpose of orthodontics.

ORTHODONTIC EXCLUSIONS

1) Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances.

2) Retreatment of orthodontic cases.

3) Changes in treatment necessitated by accident of any kind, and/or lack of patient cooperation.

4) Surgical procedures incidental to orthodontic treatment.

5) Myofunctional therapy.

6) Surgical procedures related to cleft palate, micrognathia, or macrognathia.

7) Treatment related to temporomandibular joint disturbances.

8) Supplemental appliances not routinely utilized in typical Phase II orthodontics.

9) Active treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge not to exceed $75 per month.

10) Restorative work caused by orthodontic treatment.

11) Phase I* orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion.

12) Extractions solely for the purpose of orthodontics.

13) Treatment in progress at inception of eligibility.

14) Transfer after banding has been initiated.

15) Composite bands and lingual adaptation of orthodontic bands are considered optional treatment and would be subject to additional charges.

* Phase I is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.

APPENDIX C
DENTAL PLAN SPECIFICATIONS
DUAL CHOICE DENTAL PROGRAM
DELTACARE

CONTRACT NUMBER: 10660

GROUP PLAN COMMENCEMENT DATE: June 1, 2008

BENEFIT YEAR: January 1st through December 31st.

DUAL CHOICE DENTAL PROGRAM:

The Dual Choice Dental Program (with a monthly switch option) consists of a dental fee-for-service program, referred to as Delta Dental PPO, and a dental capitation program, referred to as DeltaCare. Subscribers may move from the Delta Dental PPO program to the DeltaCare program or from the DeltaCare program to the Delta Dental PPO program on a monthly basis. A Subscriber (including his or her dependents) may only be covered under one program during any one month and may only make a change by notifying the Plan Administrator. The Plan Administrator, in turn, will notify Delta Dental no later than the 15th of the month preceding the effective date of the change.

Any treatment in progress must be completed under the group dental program in which treatment was initiated. No program changes may be made while a Subscriber, or any of his or her Dependents, is undergoing active dental treatment. Should a Subscriber change dental programs while in active dental treatment or while any of his or her Dependents is in active dental treatment, the expenses of that treatment are solely the responsibility of the Covered Individual and not Delta Dental.

Unit Rate of Contribution:

The following are the premium rates which are to be paid monthly by Group Subscriber to Delta Dental of Illinois for the initial 24-month period from June 1, 2008 to May 31, 2010:

Single:	$24.89
Employee plus Spouse:	$48.95
Employee plus Child(ren):	$47.67
Family:	$89.09

Delta Dental of Illinois warrants that the premium rates for the 12-month period from June 1, 2010 through May 31, 2011 shall not increase by more than 7.5 percent over the premium rates for the initial 24-month period.

ELIGIBILITY REQUIREMENTS:

All present regular, full-time employees of the Group Subscriber who work a minimum of 30 hours per week are eligible for coverage under this Group Dental Plan.

All present employees who are not employed full time as of the Group Plan Commencement Date, but subsequently do become full-time employees, are eligible for coverage under this Group Dental Plan on the date of full-time employment.

All future regular, full-time employees who work a minimum of 30 hours per week become eligible on the date of employment.

Domestic Partners, as defined herein, and their eligible dependents are eligible for coverage under this Group Dental Plan.

DEPENDENT CHILDREN:

"Dependent children" means those unmarried children who are:

- under the age of 26, regardless of their place of residence or student status; or
- under the age of 30, if they are Illinois residents, served as a member of the U.S.

Armed Forces (active or reserve), and have received a release or discharge other than dishonorable. Submission of proof of military service (U.S. Government Form DD2-14, Certificate of Release or Discharge from Active Duty) is required.

Coverage for dependent children terminates the end of the last day prior to attaining the limiting age.

Dependent children shall also include children of any age who are and continue to be permanently and totally disabled because of a medically determinable physical or mental impairment, where the disability commenced prior to losing dependent status as provided above.

INITIAL 90-DAY ENROLLMENT PERIOD FOR ELIGIBLE DEPENDENTS:

There is an initial 90-day enrollment period beginning on the contract renewal date of June 1, 2009 for dependent children eligible for coverage under the Illinois dependent age law. After this initial enrollment period, eligible dependent children may only enroll during an open enrollment period or if there is a qualifying family status change.

ENROLLMENT REQUIREMENTS:

Except in the event of a qualifying status change:

(a) Employees/members or their Dependents may only enroll on their effective date of coverage or during a subsequent open enrollment period.

(b) Employees/members or their Dependents who terminate coverage will not be permitted to re-enroll until an open enrollment period occurring at least twenty-four (24) months after the date of termination.

(c) Once enrolled, employees/members or their Dependents must remain enrolled for the duration of the Benefit Period.

APPENDIX D
COORDINATION OF BENEFITS

The purpose of this group dental plan is to help you meet the cost of needed dental care or treatment. It is not intended that anyone receive benefits greater than actual expenses incurred. In no event will payment by this group dental plan exceed the amount that would have been allowed if other dental coverage did not exist.

For services rendered by a panel dentist or panel orthodontist, the benefits under this group dental plan always are paid as primary; that is, its benefits are determined without considering any other plan's benefits.

For specialty claims and claims for emergency services, if a *covered individual* is entitled to dental coverage under two or more policies or prepaid health care plans, then the benefits under this group dental plan shall be limited as follows:

(a) The benefits of the plan that covers the person directly as the employee/member and not as a *dependent* will be determined before those of the plan that covers the person as a *dependent*.

(b) Except as set forth in paragraph (c), when two or more plans cover the same child as a *dependent* of different parents:

1. The benefits of the plan of the parent whose birthday, excluding year of birth, falls earlier in a year will be determined before those of the plan of the parent whose birthday, excluding year of birth, falls later in a year; but

2. If both parents have the same birthday, the benefits of the plan that covered the parent for a longer period of time will be determined before those of the plan that covered the parent for a shorter period of time.

(c) If two or more plans cover a *dependent* child of divorced or separated parents, benefits of the child will be determined in this order:

1. First, the plan of the parent with custody of the child;

2. Second, the plan of the spouse of the parent with custody of the child; and

3. Third, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obliged to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This rule does not apply with respect to any claim determination period or *benefit period* during which any benefits are actually paid or provided before that entity has that actual knowledge.

Notwithstanding the foregoing, if the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules as set forth in paragraph (b).

(d) The benefits of a plan that covers a person as an employee who is neither laid off nor retired, or as that employee's *dependent*, will be determined before those of a plan that covers that person as a laid off or retired employee or as that employee's *dependent*. If the other plan is not subject to this rule, and if, as a result, the plans do not agree on the order of benefits, this paragraph shall not apply.

(e) If none of the rules in paragraphs (a), (b), (c) or (d) determine the order of benefits, the benefits of the plan that covered an employee/member for a longer period of time will be determined before those of the plan that covered that person for the shorter period of time.

(f) Notwithstanding the foregoing, when two plans provide coverage and only one has a coordination of benefits provision, the plan without the coordination of benefits provision is automatically deemed primary.

If this group dental plan provides only secondary coverage, no payment shall be required under this group dental plan until we receive a copy of the primary plan's proof of payment and calculation of benefits.

Where an individual has dual coverage, this group dental plan shall not be charged with a greater amount than the amount for which it would be liable if such dual coverage did not exist. In any event, the benefits under both plans shall not total more than the dentist's billed fees.

APPENDIX E
PRE-SERVICE REQUESTS AND POST-SERVICE CLAIM DETERMINATIONS AND APPEAL PROCEDURES

Urgent Care Referral Requests (Emergency Referrals)

In the case of a request for emergency referral where pre-authorization of proposed treatment by the *specialist* is required, Delta Dental shall notify you and the *specialist* of its determination, whether adverse or not, as soon as possible, but not later than 72 hours after receipt of the request for pre-authorization. The notice shall include a description of the expedited review and appeal process applicable to urgent care claims. If the *specialist* fails to provide sufficient information for us to render a decision on the proposed treatment, we will notify you and the *specialist* of the specific information required as soon as possible, but not later than 24 hours after receipt of the claim. The *specialist* shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. We will notify you and the *specialist* of our determination as soon as possible, but no later than 48 hours after the earlier of (a) our receipt of the specified information or (b) the end of the period afforded the *specialist* to provide the additional information.

Non-Urgent Pre-Service Referral Requests (Specialty Referrals) Where Pre-Authorization Is Required

In the case of a request for referral to a *specialist* (pre-service claim) where the *specialist* must submit a request for pre-authorization to Delta Dental, we will notify you and the *specialist* of our benefit determination, whether adverse or not, within a reasonable period of time appropriate to the circumstances, but not later than 15 days after the referral request is filed. This period may be extended one time for up to 15 days if necessary due to matters beyond our control. If an extension is necessary, we will notify you and the *specialist* within the original 15-day period, of the circumstances requiring the extension and the date by which we expect to render a decision. If an extension is needed because the *specialist* did not submit information necessary for us to render a decision on the proposed treatment, the notice of extension shall specifically describe the required information. The *specialist* shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Post-Service Claims and Pre-Service Requests Not Requiring Pre-Authorization

If you make a post-service claim for benefits under this group dental plan or a pre-service request for predetermination of benefits where pre-authorization is not required, and your claim or predetermination request is denied, in whole or in part, you will receive written notification within a reasonable period of time, but not later than 30 days after receipt of the claim. The notice will be an “Explanation of Benefits,” also called an “adverse benefit determination.” We may extend this period one time up to 15 days, provided that we determine that such an extension is necessary for reasons beyond our control and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and you shall be afforded 45 days from receipt of the notice within which to provide the specified information.

The written notification advising you of the adverse benefit determination – Explanation of Benefits – will include the following information:

- Through the use of a reference code (numerical code), a statement of the specific reason(s) why the claim was denied, in whole or in part, including specific plan provisions on which the denial is based and a description of any additional information needed in order to perfect the claim as well as the reason why such information is necessary;

- A description of Delta Dental's appeal process and the time limits applicable to the process, including, if this group dental plan is subject to the federal law known as the Employee Retirement Income Security Act (“ERISA”), a statement of the enrollee's right to bring a civil action under ERISA following an adverse benefit determination;

- If applicable, through the use of a reference code (numerical code), a statement of the specific rule, guideline or protocol relied upon in making the adverse benefit determination;

- If applicable, through the use of a reference code (numerical code), a statement of the relevant scientific or clinical judgment, if the adverse benefit determination is related to dental necessity, experimental treatment or other similar exclusion or limitation.

If you have a complaint regarding the quality of dental services rendered by a *panel dentist*, the appeal process described above may be used to file such a complaint.

Information concerning appeal procedures also may be obtained by calling our customer service department.

Contesting a Claim Denial

If you do not use the claim procedures described below, and if you file a lawsuit to contest an adverse determination of benefits, your lawsuit may not be heard by the court because you failed to utilize your group dental plan's internal claims procedures.

Request for Appeal of Adverse Benefit Determination - Urgent Care Referral Request (Emergency Referral): If an expedited review of denial of a referral request involving urgent care is necessary, you or the *specialist* may request such review orally by telephone at 1-800-942-3772 or in writing by facsimile or other similarly expeditious method. We will notify you of the determination on review as soon as possible, but no later than 72 hours after receipt of the request for review.

Request for Appeal of Adverse Benefit Determination - Post-Service Claim or Non-Urgent Pre-Service Request: To appeal a denial of a post-service claim or a non-urgent pre-service request (non-urgent specialty referral where pre-authorization is required, or predetermination of benefits), you must first file an appeal.

Your appeal must be in writing and must be made within 180 days of the date of the initial adverse benefit determination. The written appeal must state why you believe that Delta Dental's denial was incorrect. The denial notice, as well as any other documents or information bearing on the pre-service authorization or predetermination request or claim, should accompany your appeal. If requested, you will be provided, free of charge, reasonable access to and copies of all documents, records and other information relevant to the denied request or claim.

You should address your appeal as follows:

Delta Dental of Illinois
Attention: Reevaluation Committee
P.O. Box 3399
Lisle, Illinois 60532

Reevaluation Committee's Review: The Reevaluation Committee's review of the request or claim upon appeal will take into account all comments, documents, records or other information submitted by you, regardless of whether such information was submitted or considered in the initial benefit determination. The review by the Revaluation Committee will not afford deference to the initial adverse benefit determination. The review shall be conducted by a person who is neither the individual who made the initial denial nor a subordinate of that individual. If the review is of an adverse benefit determination based in whole or in part on a determination related to dental necessity, experimental treatment or a clinical judgment in applying the terms of your group's contract, the Reevaluation Committee shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the dental consultant who made the initial denial nor the subordinate of such consultant. The Reevaluation Committee shall provide, upon your request, the name of any dental consultant whose advice was obtained in connection with the denial, whether or not that advice was relied upon in making the initial benefit determination.

Notice of Review Decision:

For appeal of the denial of an urgent care referral, the plan shall notify you of its decision as soon as possible, but not later than 72 hours after receipt of the request for review.

For appeal of the denial of a non-urgent pre-authorization request (specialty referral), the Reevaluation Committee shall notify you in writing of its decision on the appeal within a reasonable period of time appropriate to the circumstances, but not later than 30 days after receipt of the request for review.

For appeal of the denial of a post-service claim or pre-service predetermination request where pre-authorization is not required, the Reevaluation Committee shall notify you in writing of its decision on the appeal within 60 days of receipt of request for review.

If the Reevaluation Committee upholds the adverse benefit determination on appeal, the notice shall include the following information:

- Through the use of a reference code (numerical code), a statement of the specific reason for the adverse determination, including specific plan provisions upon which the determination is based;

- A statement that reasonable access to and copies of all documents, records and other information relevant to the denied claim are available free or charge upon request;

- If this group dental plan is subject to the federal law known as the Employee Retirement Income Security Act ("ERISA"), a statement of the claimant's right to bring a civil action under ERISA;

- If applicable, through the use of a reference code (numerical code), a statement of the specific rule, guideline or protocol relied upon in making the adverse determination; and

- If applicable, through the use of a reference code (numerical code), a statement of the relevant scientific or clinical judgment; if the adverse benefit determination is related to dental necessity, experimental treatment or other similar exclusion or limitation.

Filing a Lawsuit To Contest an Adverse Benefit Determination; Your Two-Year Deadline

You have the right to bring a lawsuit to contest in court an adverse benefit determination on appeal. You may sue in either state court or federal court under the federal Employee Retirement Income Security Act, although, if you file in state court, the case may nevertheless be transferred to federal court.

ANY LAWSUIT TO CONTEST AN ADVERSE BENEFIT DETERMINATION MUST BE COMMENCED NO LATER THAN TWO YEARS AFTER THE DATE OF THE INITIAL ADVERSE DETERMINATION.

APPENDIX F
CONTINUATION OF COVERAGE

This Appendix contains important information about continuation coverage which may be available to Covered Individuals under federal and/or Illinois law. It is also available on Delta Illinois' Web site. Part A describes continuation coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") for temporarily continuing coverage at group rates in certain instances when coverage would otherwise end. It applies to employers with 20 or more employees. Part B describes continuation coverage available during a leave under the Family and Medical Leave Act of 1993 ("FMLA") applicable to employers with 50 or more employees. Part C describes continuation coverage available to Subscribers who take a military leave and their eligible Dependents under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). It is applicable to group health plans. Part D describes the options available for a Subscriber's spouse and his/her eligible Dependents for continuing coverage under Illinois law.

Part A

Continuation Coverage Rights Under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") (for employees and Dependents)

The right to COBRA continuation coverage, which is a temporary extension of coverage, was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you and to other members of your family who are covered under this group dental plan when you would otherwise lose your group dental coverage. ***The purpose of this Part A is to explain COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.***

The Plan Administrator is responsible for administering COBRA continuation coverage. The Plan Administrator may in the future arrange with a contract administrator to fulfill certain of the Plan Administrator's responsibilities pertaining to COBRA continuation coverage. In that event, the contract administrator will carry out many of the functions described in this section as being carried out by the Plan Administrator, such as sending notifications or receiving elections and Premiums. You will be advised by the Plan Administrator of the name, address and telephone number of the party responsible for administering COBRA continuation coverage if it is someone other than the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a temporary extension of coverage that would otherwise end because of a life event known as a "qualifying event" occurs and any required notice of that event is properly provided to the Plan Administrator. Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under this group dental plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, Dependent children of employees, and a child who is born to or placed for adoption with an employee during a period of continuation coverage may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

In general, an individual (other than a child who is born to or placed for adoption with an employee during a period of continuation coverage) who is not covered under this group dental plan on the day before the qualifying event cannot be a qualified beneficiary with respect to that qualifying event. The reason for the individual's lack of actual coverage (such as the individual's having declined participation in the group dental plan or failed to satisfy conditions for participation in this group dental plan) is not relevant for this purpose. However, if the individual is denied or not offered group dental coverage under circumstances in which the denial of or failure to offer coverage constitutes a violation of applicable law, then the individual will be considered to have had the coverage that was wrongfully denied or not offered.

Continuation coverage is the same coverage that this group dental plan gives to other participants who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights and obligations under this group dental plan as other participants covered under this group dental plan, including, without

limitation, the provisions governing open enrollment, coverage limits, payment policies and any managed care limitations or requirements.

What Qualifying Events Might Trigger COBRA Coverage?

If you are an employee, you will become a qualified beneficiary if you lose your coverage under this group dental plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under this group dental plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under this group dental plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee and other parent become divorced or legally separated; or
- Your child stops being eligible for coverage under your group dental plan as a Dependent.

How Close in Time Must the Qualifying Event Be to the Loss of Coverage?

For purposes of determining whether a qualifying event has occurred, a loss of coverage need not occur immediately after the event, so long as it occurs before the end of the maximum COBRA coverage period associated with that event. However, if neither the employee nor another qualified beneficiary loses coverage before what would be the end of such maximum coverage period, then the event is not a qualifying event.

If a potential qualified beneficiary's coverage is reduced or eliminated in anticipation of an event, the reduction or elimination is disregarded in determining whether the event causes a loss of coverage. For example, if you drop coverage for your spouse several months early in anticipation of a divorce or legal separation, then, upon receiving notice of the divorce or legal separation in a timely manner, continuation coverage will be made available to such person, effective on the date of the divorce or legal separation (but not for any period before the date of divorce or legal separation).

When Will Notice of a Qualifying Event Be Given Automatically to the Plan Administrator?

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan Administrator will be deemed to have been notified automatically.

When Must You Give Notice of a Qualifying Event or Other Event that May Affect COBRA Coverage?

For other qualifying events that may trigger, extend, or otherwise affect the COBRA continuation coverage of you, your spouse, or your children, you are under an obligation to give written notice to the Plan Administrator of the event. ***Failure to do so may trigger a loss of COBRA continuation coverage for you, your spouse, or your child or children.***

Either you, your spouse, your child, or a representative acting on behalf of you, your spouse, or your child may provide the notice. The events which trigger a responsibility on your part to notify the Plan Administrator in writing are as follows:

Divorce or Legal Separation. You must notify the Plan Administrator in writing if you become divorced or legally separated from your spouse. You must include with your written notice your name, address, contact telephone number, and a copy of the divorce decree or court order of separation. You must provide the written notice within 60 days of the date on which the divorce or legal separation occurs or the date on which your spouse loses (or would lose) coverage under this group dental plan as a result of the divorce or legal separation, whichever is later. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, you must notify the Plan Administrator within 60 days after the divorce or legal separation that your coverage was reduced or eliminated in anticipation of the divorce or legal separation. You must provide evidence satisfactory to the Plan Administrator that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

***Child Ceasing to Qualify for Coverage*.** You must notify the Plan Administrator in writing if one or more of your children stops being eligible under this group dental plan as a Dependent child. You must include with your written notice your name, address, contact telephone number, the name of your child, and an explanation of how your child ceased to be an eligible Dependent. You must provide the written notice within 60 days of the date on which your child ceases to qualify for coverage under this group dental plan or the date on which your child loses (or would lose) coverage under this group dental plan, whichever is later.

Second Qualifying Event. You must notify the Plan Administrator in writing if your family experiences a second qualifying event, while receiving 18 months of COBRA continuation coverage, that would extend the maximum period of continuation coverage from 18 (or 29) months to 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a Dependent child's losing eligibility as a Dependent child under the group dental program. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the group dental program if the first qualifying event had not occurred. You must include with your written notice your name, address, contact telephone number, and a description of the second qualifying event and precisely when it occurred. You must provide the written notice within 60 days of the date on which the second qualifying event occurs or the date on which you or another qualified beneficiary loses (or would lose) coverage at the end of the initial maximum period of COBRA coverage, whichever is later.

Determination of Disability by Social Security Administration. You must notify the Plan Administrator in writing if the Social Security Administration determines that a qualified beneficiary is disabled. This disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must include with your written notice your name, address, contact telephone number, the name of the disabled qualified beneficiary, and a copy of the determination by the Social Security Administration. You must provide the written notice within 60 days of (i) the date of the disability determination by the Social Security Administration, (ii) the date on which the qualifying event occurred, (iii) the date on which the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event, or (iv) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice, whichever is later.

Determination of End of Disability by Social Security Administration. You must notify the Plan Administrator in writing if the Social Security Administration determines that a qualified beneficiary is no longer disabled. You are required to notify the Plan Administrator only if notice of disability within the first 60 days of continuation coverage was given to the Plan Administrator in order to obtain the extension of COBRA coverage by reason of disability. You must include with your written notice your name, address, contact telephone number, the name of the formerly disabled qualified beneficiary, and a copy of the determination by the Social Security Administration. You must provide the written notice within 30 days of the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

When Does COBRA Coverage Start?

Once the Plan Administrator receives written notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will generally begin on the date of the qualifying event.

When Does COBRA Coverage Normally Last Up to 18 Months? When Does COBRA Coverage Normally Last Up to 36 Months?

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended: (i) a qualified beneficiary becomes disabled; or (ii) a second qualifying event occurs. These two methods for extending continuation coverage are discussed below.

When the qualifying event is the death of the employee, your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to 36 months.

When Does a Disability Extend COBRA Coverage Up to a Maximum of 29 Months?

If you or anyone in your family covered under this group dental plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of the COBRA continuation coverage period, the COBRA continuation coverage period may be extended by 11 months to a total maximum of 29 months if certain conditions are satisfied. The conditions that must be satisfied are as follows:

- The qualifying event must be your termination of employment or reduction in hours;
- The qualified beneficiary (who may be you or your spouse or your Dependent child) must be determined under the Social Security Act to have been disabled at any time during the first 60 days of the COBRA continuation coverage period; and
- The qualified beneficiary must notify the Plan Administrator of the disability determination as set forth above under "When Must You Give Notice of a Qualifying Event or Other Event that May Affect COBRA Coverage?" ***This notice should be sent to the Plan Administrator at the address shown in this booklet.***

If the foregoing conditions are satisfied, the disability extension applies to all qualified beneficiaries (all family members who had coverage) with respect to the qualifying event, not only to the disabled qualified beneficiary.

If the qualified beneficiary (who may be you or your spouse or your Dependent child) is determined by the Social Security Administration to no longer be disabled, you must notify the Plan Administrator of that fact within 30 days of the Social Security Administration's determination.

When Does a Second Qualifying Event Extend the 18-Month Period of COBRA Coverage Up to a Maximum of 36 Months?

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and Dependent children in your family can get additional months of COBRA continuation coverage, up to a total maximum of 36 months. This extension is available to your spouse and Dependent children if you die, or get divorced or legally separated. The extension is also available to a Dependent child when that child stops being eligible under this group dental plan as a Dependent child.

When May COBRA Coverage Be Cut Off Early?

The right to continue group health plan coverage that has been elected for a qualified beneficiary will end before the last day of the maximum continuation coverage period upon the earliest of the following dates:

- The first day for which timely payment for continuation coverage is not made with respect to the qualified beneficiary.
- The date on which the employer ceases to provide any group dental plan coverage to any employee.
- The date, after the date of election of continuation coverage, upon which the qualified beneficiary first becomes actually covered under any other group dental plan (as an employee or otherwise) which does not contain any exclusion or limitation for any preexisting condition of that qualified beneficiary (other than an exclusion or limitation which does not apply to or is satisfied by the qualified beneficiary).
- The date your Plan Administrator terminates for cause the coverage of a qualified beneficiary on the same basis that your Plan Administrator terminates for cause the coverage of similarly situated enrollees who have not elected continuation coverage (such as filing fraudulent claims).

How Do You (or Another Qualified Beneficiary) Elect Continuation Coverage?

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both you and your spouse may elect continuation coverage, or you may elect COBRA continuation coverage on behalf of your spouse. Parents may elect to continue coverage on behalf of their Dependent children only. A qualified beneficiary must elect coverage by the date specified on the election form provided by the Plan Administrator. Failure to do so will result in loss of the right to elect continuation coverage under this group dental plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you submit the revised election.

How Much Does Continuation Coverage Cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost (including both the employer and employee contributions) for coverage of a similarly situated enrollee who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent), plus any additional amounts that are permitted by COBRA. Required contributions for qualified beneficiaries electing continuation coverage may be increased by the employer from one year to the next.

When and How Must Your First Payment for Continuation Coverage Be Made?

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the election form provided by the Plan Administrator. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the election notice is marked with a U.S. postmark, if mailed.) ***If you do***

not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under this group dental plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under this group dental plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the Plan Administrator to confirm the correct amount of your first payment.

When and How Must Your Subsequent Payments for Continuation Coverage Be Made?

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under this group dental plan, these subsequent periodic payments for continuation coverage are due on the first day of the month for which the contribution is made. If you make a periodic payment on or before its due date, your coverage under this group dental plan will continue for that coverage period without any break. You will not be sent periodic notices of payments due for these coverage periods.

Payment is considered made on the date it is sent to the Plan Administrator as evidenced by the U.S. postmark date.

Is There Any Grace Period for Your Subsequent Payments for Continuation Coverage?

Although subsequent periodic payments are due on the first day of the month for which you are requesting coverage, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

Should you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under this group dental plan. As a precondition for dropping coverage, the Plan Administrator must provide written notice to you that the payment has not been received. This notice shall be mailed to you at least 15 days before coverage is to cease, advising that coverage will be dropped on a specified date at least 15 days after the date of the notice unless payment has been received by that date. Coverage for you will cease at the end of the 30-day grace period where the required 15-day notice has been provided.

To Whom Should You Direct Questions?

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

Keep the Plan Administrator Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Part B

Continuation Coverage Rights Under the Family and Medical Leave Act of 1993 ("FMLA")
(for employees)

What Happens to Your Coverage If You Take a Leave of Absence?

Normally, you have no right to continue any coverage under this group dental plan while you are on a leave of absence unless you have exercised your rights described in Part A of this Appendix. The only exceptions are for leave under the Family and Medical Leave Act of 1993 ("FMLA") and military leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), as described in this section.

Leave Under the Family and Medical Leave Act

Continuation of group dental plan coverage and reinstatement of coverage under this group dental plan is available to employees and their covered eligible Dependents under certain specified conditions.

An employee who takes a leave of absence under the FMLA is entitled to continue coverage under this group dental plan for himself/herself and his/her covered eligible Dependents to the same extent as if the employee had been actively at work during the entire leave period permitted by FMLA, subject to the terms and conditions set forth below.

What Happens If Payments Are Not Made During FMLA Leave?

If you do not make the required payments for coverage for yourself (and any covered eligible Dependents), coverage will cease. Your payment must be received within 30 days of the date the payment is due. The obligation to maintain coverage under this group dental plan during FMLA leave ceases if the employee's contribution is more than 30 days late. As a precondition to dropping coverage during FMLA leave, the Plan Administrator must provide written notice to the employee that the payment has not been received. The notice shall be mailed to the employee at least 15 days before coverage is to cease, advising that coverage will be dropped on a specified date at least 15 days after the date of the notice unless payment of the contribution has been received by that date. Coverage for the employee and his/her eligible Dependents shall cease at the end of the 30-day grace period, where the required 15-day notice has been provided.

The employer may recover the employee's required contribution payments missed by the employee for any FMLA leave period during which the employer maintains coverage under this group dental plan by paying the employee's contribution after the payment is missed.

The employer reserves all rights, as permitted and as limited by the FMLA and its regulations, to recover its share of the applicable cost of coverage during a period of an unpaid FMLA leave for an employee if the employee fails to return to work after the employee's FMLA leave entitlement has been exhausted or expired.

Will Your Coverage Be Reinstated Upon Return from FMLA Leave?

If you decline coverage during your leave or if your coverage is terminated as a result of your failure to pay any required contributions, you shall, upon return from the leave permitted by the FMLA, be entitled to be reinstated to coverage under the group dental plan on the same terms as prior to taking leave, without any waiting period, physical examination, or exclusion as to preexisting conditions, but subject to the group dental plan's eligibility rules.

When Does COBRA Start If You Do Not Return from FMLA Leave?

If you take FMLA leave and do not return to work at the end of your leave, you and your covered eligible Dependents will be entitled to elect COBRA coverage if (i) they were covered under the group dental plan on the day before FMLA leave began (or became covered during FMLA leave); and (ii) they will lose group dental coverage within 18 months because of your failure to return to work at the end of FMLA leave. COBRA coverage elected in these circumstances will begin on

the last day of FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours.

Part C

Continuation Coverage Rights under the Uniformed Services Employment and Reemployment Rights Act ("USERRA")(for employees)

Military Leave Under the Uniformed Services Employment and Reemployment Rights Act

In accordance with USERRA, continuation coverage under this group dental plan is available to employees/members (collectively referred to as "employees") who take military leave and their covered eligible Dependents under certain specified conditions. You must give the Plan Administrator written notice within 60 days of your absence from employment for military service of your desire to elect continuation coverage under USERRA.

The requirement of written notice within 60 days, however, does not apply if that type of notice is precluded by military necessity or if the giving of that type of notice is impossible or unreasonable under the circumstances. In that event, the notice may be as late as is reasonable under the circumstances. Similarly, the notice may be oral if written notice would be unreasonable under the circumstances.

Any extension of benefits period provided pursuant to this section will not postpone the starting date for measurement of the maximum period available for continuation of benefits pursuant to the COBRA continuation coverage provisions set forth in Part A of this Appendix. In other words, COBRA coverage and USERRA coverage will run concurrently because the events giving rise to the respective rights occur at the same time.

What Group Health Plan Coverage Will Be Provided?

You may elect to continue group dental coverage for yourself and your covered eligible Dependents if coverage would otherwise cease under this group dental plan due to your absence from employment by reason of your service in the uniformed services. To elect to continue group dental coverage under USERRA, you should complete the appropriate election and pay the applicable Premium, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

Benefits under this group dental plan for employees under an election for military leave continuation coverage shall be the same coverage as provided to all other enrollees. If benefits under this group dental plan are increased, decreased, or otherwise amended or changed either prior to or subsequent to the election of continuation coverage, the benefits provided pursuant to this continuation coverage will be the same as those available to all other enrollees. You may not, however, initiate new coverage at the beginning of a period of service if you did not previously have such coverage.

How Much Do You Have to Pay to Continue Your Health Plan Coverage?

If you elect to continue group dental coverage under USERRA, you may be required to pay up to 102 percent of the full Premium under this group dental plan (the same rate as with COBRA coverage). Notwithstanding the foregoing, in the event you perform services in the uniformed services for less than 31 days, you will not be required to pay more than your share, if any, for such coverage.

How Long Does USERRA Coverage Last?

The maximum period of coverage available to all enrollees under the provisions of this section shall be the lesser of:

(1) the 24-month period beginning on the date on which your absence for the purpose of performing service begins; or

(2) the period beginning on the date on which your absence for the purpose of performing service begins, and ending on the date on which you fail to return from service or apply for a position of employment as provided under section 4312(e) of USERRA.

In the event you fail to pay the required Premiums, coverage will be cancelled. In addition, coverage will be terminated if you lose your rights under USERRA as a result of certain types of undesirable conduct, such as court-martial and dishonorable discharge.

If Coverage Was Terminated During Military Service, Must Coverage Be Reinstated Upon Reemployment?

If group dental coverage or your Dependent's coverage was terminated by reason of your service in the uniformed services, that coverage must be reinstated upon reemployment. An exclusion or waiting period may not be imposed in connection with the reinstatement of your coverage upon reemployment if an exclusion or waiting period would not have been imposed had your coverage not been terminated by reason of such service.

The group dental plan may impose an exclusion or waiting period as to illnesses or injuries determined by the Secretary of Veterans Affairs or his or her representative to have been incurred in, or aggravated during, performance of service in the uniformed services. Other coverage, for injuries or illnesses that are not service-related (or for an employee's eligible Dependents, if the employee has Dependent coverage) must be reinstated. The employer will reinstate your group dental coverage upon request at reemployment. You may not delay reinstatement of group dental coverage until a date that is later than the date of your reemployment.

Part D

Continuation Coverage Rights Under Illinois Law (for covered spouses)

Under Illinois law, the spouse of an employee/member (referred to collectively as "employee") may have a right to continuation coverage for him/herself and his/her Dependent children when they would otherwise lose group dental coverage. ***The purpose of Part D is to explain Illinois continuation coverage, when such coverage may become available to your spouse and Dependent children, and what your spouse needs to do to protect the right to receive it.***

What Is Illinois Continuation Coverage?

Illinois continuation coverage is a continuation of group dental coverage that would otherwise end because of a life event known as a "terminating event." Specific terminating events are listed below. An employee's spouse and Dependent children who were covered under the provisions of the group dental plan at the time of the terminating event will be eligible for Illinois continuation coverage.

Continuation coverage is the same coverage that this group dental plan gives to other enrollees who are not receiving continuation coverage. Each individual who elects Illinois continuation coverage will have the same rights and obligations under this group dental plan as other covered enrollees.

What Life Events Are "Terminating Events" That Trigger Illinois Continuation Coverage?

Your spouse will become eligible for Illinois continuation coverage for him/herself and eligible Dependent children if the spouse will lose coverage under the Plan because any of the following life events happens:

- You die;
- You become divorced from your spouse; or

- You retire (but only if your spouse is age 55 or over).

Is Your Spouse Required To Give Any Notice of a Terminating Event to Delta Dental or to the Plan Administrator?

Delta Dental will offer Illinois continuation coverage to a former spouse or retired employee's spouse (and Dependent children, if applicable) only after being notified in writing by either the spouse or the Plan Administrator that a terminating event has occurred. Your spouse must notify Delta Dental or the Plan Administrator in writing within 30 days after the terminating event occurs. If notice is sent to the Plan Administrator, the Plan Administrator, within 15 days of receiving such notice, must notify Delta Dental of the terminating event and the address of the former spouse or retired employee's spouse.

When Does Illinois Continuation Coverage Start?

Within 30 days of receiving notice that a terminating event has occurred, Delta Dental will notify the spouse via certified mail, return receipt requested, that coverage under the group dental plan may be continued for the spouse and covered Dependent children. If the spouse elects Illinois continuation coverage, such coverage will begin on the date of the terminating event.

How Long Does Illinois Continuation Coverage Normally Last?

When the terminating event is death of the employee or divorce and the former spouse is under age 55 at the time continuation coverage begins, Illinois continuation coverage lasts for up to two years.

When the terminating event is death of the employee, divorce, or retirement of the employee and the former spouse or retired employee's spouse has attained the age of 55 at the time continuation coverage begins, Illinois continuation coverage may last until the date the spouse reaches the qualifying age for or otherwise establishes eligibility under Medicare, unless continuation coverage is cut off before that date as described below.

When May Illinois Continuation Coverage Be Cut Off Early?

The right to continue group health plan coverage elected under Illinois law will end before the last day of the maximum continuation coverage period upon the earliest of the following dates:

- The first day for which timely payment for continuation coverage is not made to Delta Dental when due (including any grace period allowed under the group dental plan) by the former spouse or retired employee's spouse;

- For a spouse who was under age 55 when continuation coverage began, the date coverage would otherwise terminate for the employee, but not during the first 120 consecutive days following the employee's death or divorce, unless the group dental plan is modified or terminated as to all employees;

- For a spouse who had attained age 55 when continuation coverage began, the date coverage would otherwise terminate for the employee (except due to the retirement of the employee), but not during the first 120 consecutive days following the employee's death or divorce, unless the group dental plan is modified or terminated as to all employees;

- The date on which the former spouse remarries;

- The date on which the former spouse or retired employee's spouse becomes, after the date of election, an insured employee under any other group dental plan.

How Does Your Spouse Elect Continuation Coverage?

Your spouse has the right to elect continuation coverage for him/herself and any covered Dependent children. Delta Dental's notice to the spouse of the option to continue coverage under Illinois law will include the amount of periodic Premiums to be charged and the method and place of payment, as well as instructions for returning the election form. Within 30 days of receiving notice from Delta Dental, the spouse must notify Delta Dental by certified mail, return receipt requested, of his/her intent to continue coverage and pay the required initial Premium. ***Failure to exercise the option to continue coverage and pay the required initial premium within 30 days of receiving notice from Delta Dental will terminate the spouse's right to Illinois continuation coverage for him/herself and covered Dependent children.***

How Much Does Illinois Continuation Coverage Cost?

Generally, the spouse will be required to pay the entire cost of continuation coverage.

For a former spouse who has not reached age 55 when continuation coverage begins, the amount the spouse will pay may not exceed 100 percent of the cost to Group Subscriber (including both employer and employee contributions) for coverage of a similarly situated enrollee who is not receiving continuation coverage.

For a retired employee's spouse or a former spouse who has attained age 55 when continuation coverage begins, the amount the spouse will pay for the first two years of continuation coverage may not exceed 100 percent of the cost to Group Subscriber (including both employer and employee contributions) for coverage of a similarly situated plan participant who is not receiving continuation coverage. Beginning two years after continuation coverage begins, the amount the spouse pays for continuation coverage may include an additional charge, not to exceed 20 percent of the cost of the coverage to the Group Subscriber, for costs of administration.

Required contributions for spouses electing Illinois continuation coverage may be increased by the employer from one year to the next.

When and How Must the First Payment for Continuation Coverage Be Made?

If Illinois continuation coverage is elected, the spouse must send the initial payment for continuation coverage to Delta Dental with the election form provided by Delta Dental.

The first payment must cover the cost of continuation coverage from the time coverage under the group dental plan would have otherwise terminated up to the time the first payment is made. The spouse is responsible for making sure that the amount of the first payment is enough to cover this entire period. The spouse may contact Delta Dental to confirm the correct amount of the first payment and where that payment should be sent.

When and How Must Subsequent Payments for Continuation Coverage Be Made?

After the spouse makes the first payment for continuation coverage, he/she will be required to pay for continuation coverage for each subsequent month of coverage. Under this group dental plan, these periodic payments for continuation coverage are due on the first day of the month for which the contribution is made. If a periodic payment is made on or before its due date, coverage will continue for that coverage period without any break. Delta Dental will not send periodic notices of payments due for these coverage periods.

Is There Any Grace Period for Subsequent Payments for Continuation Coverage?

Although periodic payments are due on the first day of the month for which coverage is requested, the spouse will be given a grace period of 30 days to make each periodic payment. Continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

Payment is considered made on the date it is sent to Delta Dental as evidenced by the U.S. postmark date. ***If the spouse fails to make a periodic payment before the end of the grace period for that payment, he/ she will lose all rights to Illinois continuation coverage for him/herself and, if applicable, Dependent children.***

To Whom Do I Direct My Questions?

For questions about Illinois continuation coverage, you should contact Delta Dental.

Keep the Plan Informed of Address Changes

In order to protect his/her rights, the spouse should keep the Plan Administrator informed of any change of address. The spouse should also keep a copy of any notices he/she sends to the Plan Administrator or Delta Dental.

How Does Electing Illinois Continuation Coverage Affect My Spouse's Right to Continue Coverage Under COBRA?

A spouse who is eligible for continuation coverage under both Illinois law and COBRA due to a loss of group dental plan coverage may elect either Illinois or COBRA continuation coverage, but not both. Illinois and COBRA continuation coverage periods run at the same time and may not be added together. For example, an eligible spouse may not elect Illinois continuation coverage and then, when Illinois continuation coverage ends, elect COBRA continuation coverage.

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