



Delta Dental PPO

Dental Benefit Booklet

A.E.R.O. Special Education Cooperative

Group #2019
Effective Date: 07/01/09



Delta Dental of Illinois



DENTAL BENEFITS BOOKLET

This is a summary of your Group Dental Plan
prepared for Covered Individuals with:

A.E.R.O. Special Education Cooperative

IMPORTANT: THIS BOOKLET IS INTENDED TO PROVIDE A BRIEF DESCRIPTION OF YOUR DENTAL PLAN. THIS DESCRIPTION IS BASED ON OFFICIAL LEGAL DOCUMENTS. IF THERE IS ANY CONFLICT BETWEEN THIS BOOKLET AND THE COMPLETE TEXT OF THE PLAN DOCUMENT, THEN THE PLAN DOCUMENTS GOVERN AND SHALL SUPERSEDE THIS BOOKLET. YOU MAY REVIEW THE COMPLETE PLAN DOCUMENT AT THE COMPANY'S OFFICES DURING REGULAR BUSINESS HOURS AND MAY OBTAIN COPIES OF ALL OR ANY PART OF THE PLAN DOCUMENT.

Dental Benefits Administered by

DELTA DENTAL OF ILLINOIS
801 Ogden Avenue
Lisle, Illinois 60532

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DEFINITIONS

This Group Dental Plan is subject to the following definitions:

“Approved Fee” means the lesser of the Dentist’s fee or the Maximum Plan Allowance.

“Benefit Year” means the reference period specified in the Dental Plan Specifications for purposes of determining the application of Deductibles, waiting periods and coverage limits for each Covered Individual.

“Covered Individual” means any employee or any Dependent of that employee who enrolls in this Group Dental Plan and who is entitled to receive Dental Benefits, unless and until coverage terminates as provided herein.

“Covered Individual’s Effective Date of Coverage” means the date an individual meets the required conditions of eligibility and becomes enrolled in this Group Dental Plan.

“Delta Dental PPO Dentist” means a Dentist who, by written agreement with DDIL, will provide dental services to Covered Individuals in accordance with DDIL’s negotiated fee schedules and has agreed to abide by the bylaws, rules and regulations established by DDIL.

“Dental Benefits” means those dental procedures or services which are listed in this booklet subject to the exclusions, terms and conditions contained in this booklet.

“Dental Benefits Booklet” means this booklet issued to an Enrolled Employee setting forth the terms and conditions of this Group Dental Plan. Employer shall be responsible for distributing this booklet to Enrolled Employees.

“Dental Procedures or Services Received” means the date treatment is COMPLETED for any particular Dental Benefit for the purpose of allocating the particular Dental Benefit to the appropriate Benefit Year and paying claims made under this Group Dental Plan.

“Dentist” means a licensed Dentist legally entitled to practice dentistry at the time and in the place services are provided.

“Dependent” means the employee’s spouse under federal law and eligible unmarried children (including stepchildren, adopted children, children placed for adoption with the employee, foster children, and children for whom the employee is a legal guardian). For age limitations and other eligibility requirements for dependent children, see the Dental Plan Specifications.

“Eligibility Date” means the date an employee or Dependent may become enrolled in this Group Dental Plan.

“Enrolled Employee” means an employee who has satisfied the requirements for eligibility as set forth herein and who enrolls in this Group Dental Plan and makes the required contribution, if any.

“Group Plan Commencement Date” means the date this Group Dental Plan begins pursuant to the date designated in the Dental Plan Specifications.

“Maximum Plan Allowance” means the amount that a Delta Dental Premier Dentist agrees contractually to accept as full payment for covered procedures. The Maximum Plan Allowance is calculated as a percentile of billed fees.

“Non-Delta Dental PPO Dentist” means a Dentist who has not agreed to be a Delta Dental PPO Dentist. There are two categories of Non-Delta Dental PPO Dentists. First, there are those Dentists who are Delta Dental Premier Dentists and second, there are those Dentists who are not Delta Dental Premier Dentists.

- (a) Delta Dental Premier Dentists are bound to accept DDIL’s Approved Fee as full reimbursement for their services after application of any Deductible and DDIL’s benefit payment.
- (b) Non-Delta Dental Premier Dentists have not agreed to accept DDIL’s Approved Fee as full payment of their services. Non-Delta Dental Premier Dentists may bill the patient the difference between his/her fee and DDIL’s benefit payment.

“Proof of Claim” means the required documentation set forth in the section titled *Required Documentation* as well as all the requested information indicated on DDIL’s claim form.

**GENERAL INFORMATION
ON HOW THE PLAN WORKS**

Under this Group Dental Plan, you are free to go to the Dentist of your choice; however, you will receive greater benefits if you go to a Delta Dental PPO Dentist. A list of Delta Dental PPO Dentists is available on the Delta Dental of Illinois website www.deltadentalil.com.

The level of covered Dental Benefits paid under this Group Dental Plan depends on whether you go to (1) a Delta Dental PPO Dentist, (2) a Non-Delta Dental PPO Dentist who is a Delta Dental Premier Dentist, or (3) a Non-Delta Dental PPO Dentist who is not a Delta Dental Premier Dentist. See the Schedule of Dental Benefits for a description of the payment levels for each of the above categories of Dentists.

This Group Dental Plan will pay Delta Dental PPO Dentists and Non-Delta Dental PPO Dentists who are Delta Dental Premier Dentists directly and the right to receive that payment shall not be assignable. If your Dentist is a Non-Delta Dental PPO Dentist who is not a Delta Dental Premier Dentist, you will be paid directly and the right to receive that payment shall not be assignable.

HOW TO FILE A CLAIM

TO USE YOUR GROUP DENTAL PLAN, FOLLOW THESE STEPS

- (1) Please read this Dental Benefits Booklet carefully in order to familiarize yourself with the benefits and provisions of this Group Dental Plan.
- (2) If your Dentist does not have a claim form, you may obtain one from your personnel office. Please be sure that the information portion of the claim form includes the following:
 - (a) the employee's full name and address;
 - (b) the employee's social security number;
 - (c) the name and date of birth of the person receiving dental treatment; and
 - (d) the group name and number.
- (3) If your Dentist is not familiar with this Group Dental Plan or has any questions regarding this Group Dental Plan, he/she may contact Delta Dental of Illinois, 801 Ogden Avenue, Lisle, Illinois 60532; telephone (630) 964-2400 or (1-800) 323-1743.
- (4) If your Dentist expects that the total fees for your dental treatment will exceed \$200, then DDIL recommends that a request for the predetermination of plan benefits be submitted, prior to treatment, to DDIL, P.O. Box 5402, Lisle, Illinois 60532, so that you and your Dentist are aware of the coverage afforded under this Group Dental Plan prior to services being rendered. This request must show your dental needs and a description of the procedures and services which the treating Dentist plans to perform, including the actual fees to be charged for each procedure or service.
- (5) DDIL will review the request for predetermination of plan benefits and the required documentation (as set forth in the section titled *Required Documentation*) submitted by the treating Dentist in order to determine the level of payment under this Group Dental Plan. A pre-treatment determination does not take into account other coverage you may have; DDIL coordinates its benefits with another group dental plan after treatment has been completed.
- (6) After your treating Dentist has completed the dental services outlined in the Predetermined Benefit Voucher, this voucher is to be resubmitted to DDIL indicating the date each dental procedure or service was rendered. If procedures or services are rendered after 90 days from the date this Group Dental Plan issued its payment determination, as outlined in the Predetermined Benefit Voucher, the claim must be submitted to DDIL with the required documentation set forth in the section titled *Required Documentation*. This Proof of Claim should be furnished within 90 days after you have received the Dental Benefit.

- (7) If a request for predetermination of plan benefits is not submitted in advance as requested, this Group Dental Plan reserves the right to make a determination of the level of payment, taking into account the provisions of this Group Dental Plan. A determination made by DDIL imposes no restrictions on the method of diagnosis or treatment by a treating Dentist and only relates to the level of payment which this Group Dental Plan is required to make.
- (8) Submission of a request for predetermination of plan benefits before treatment commences is not requested for:
 - (a) procedures and services where the total fees are less than \$200;
 - (b) emergency examination and treatment for accidental injuries; emergency treatment for relief of pain when not related to a final procedure; and
 - (c) oral surgery necessitated as a result of an injury.

ELIGIBILITY REQUIREMENTS

Effective Date of Coverage

- (a) Employee's Date of Eligibility: An employee is eligible to enroll in this Group Dental Plan upon satisfaction of the requirements set forth in the Dental Plan Specifications. Coverage commences on the date the employee becomes an Enrolled Employee.
- (b) Dependent's Date of Eligibility: An Enrolled Employee may elect to have his/her Dependents covered by this Group Dental Plan provided that each meets the definition of Dependent as provided herein and the contributions, if any, required of the Enrolled Employee for Dependent coverage are made. A Dependent's coverage commences on whichever of the following dates is applicable.
 - (i) An Enrolled Employee's Dependents shall have coverage under this Group Dental Plan beginning on the same date as the Enrolled Employee's coverage, if written request for coverage for his/her Dependents is made by the Enrolled Employee on the date he or she first enrolls in this Group Dental Plan.
 - (ii) Dependent coverage shall commence as of the date of the Enrolled Employee's marriage and shall include any stepchildren of the Enrolled Employee who becomes eligible because of such marriage, if written request is made by the Enrolled Employee and the required contribution is paid within 31 days after the date of marriage.
 - (iii) Dependent coverage shall commence as of the date of the birth of a newborn child of an Enrolled Employee who on such date has Dependent coverage in force or has no other living Dependents or as of the date of adoption of a child by or the date of placement for adoption with an Enrolled Employee who on such date has Dependent coverage in force and has no other living Dependents, if written request for coverage for such child is made and the required contribution is paid within 31 days after such birth or adoption.
- (c) Benefit Year: Regardless of a Covered Individual's Effective Date of Coverage, the reference period for determining the application of coverage limits shall be the Benefit Year as specified in the Dental Plan Specifications.

General Eligibility Rules

- (a) Enrollment: No individual shall be eligible for Dental Benefits under this Group Dental Plan unless listed by the employer as a Covered Individual in accordance with the provisions of this Group Dental Plan.
- (b) Dependents:
 - (i) A dependent child may continue to be eligible as a Dependent if he/she is incapable of self-support because of physical or mental incapacity (that commenced prior to losing dependent status) and if he/she

is chiefly dependent on the Enrolled Employee for support, provided proof of such incapacity and dependency is submitted within 31 days after a request by DDIL, and subsequently as may be required by DDIL, but not more frequently than annually after the incapacitated and dependent child has reached age 21.

- (ii) Each Enrolled Employee must notify employer of any changes in dependent status, if applicable, immediately upon change of status.
 - (iii) Dependents in military service are not eligible for coverage under this Group Dental Plan.
- (c) Continuation of Coverage: A Covered Individual may be eligible to continue coverage under federal law and regulations. See the section titled *Continuation of Coverage Rights (COBRA)* for continuation of coverage rights if the coverage of an employee, an employee's spouse or dependent child is terminated. A Covered Individual may also be eligible for continuation of benefits under the Federal Family and Medical Leave Act if on an unpaid leave.

Termination of Eligibility

- (a) Termination of Group Dental Plan: Eligibility for Dental Benefits under this Group Dental Plan will terminate for all Covered Individuals upon termination of this Group Dental Plan.
- (b) Termination of Individual Eligibility:
 - (i) The eligibility of an Enrolled Employee, and the eligibility of the Dependents of that Enrolled Employee, will terminate if that employee ceases to be eligible under this Group Dental Plan.
 - (ii) In no event will eligibility for any individual covered under this Group Dental Plan continue beyond the date DDIL is advised by employer to terminate that individual's eligibility, or the date on which employer fails to remit the required payment for the individual.
- (c) Completed Treatment: If a Covered Individual should lose eligibility under this Group Dental Plan for any reason, no Dental Benefits will be paid or otherwise discharged after that termination date except for treatment completed on or before the date of termination.

DENTAL BENEFITS

This Group Dental Plan will pay for those dental services or procedures listed in the Schedule of Dental Benefits. Benefit payments are subject to any applicable Deductible, waiting periods and coverage limits listed in the Dental Plan Specifications.

The Dental Benefits furnished under this Group Dental Plan are limited and defined as set forth in the Schedule of Dental Benefits. A request for predetermination of plan benefits, accompanied by any required documentation, should be submitted to DDIL for payment determination before services are rendered. A determination made by DDIL imposes no restrictions on the method of diagnosis or treatment by a treating Dentist and only relates to the level of payment which this Group Dental Plan is required to make.

Not all dental services and procedures are covered under this Group Dental Plan. See the Schedule of Dental Benefits for a list of services and procedures not covered.

LEVEL OF DENTAL BENEFITS

The level of covered Dental Benefits under this Group Dental Plan depends on whether a Covered Individual goes to (1) a Delta Dental PPO Dentist, (2) a Non-Delta Dental PPO Dentist who is a Delta Dental Premier Dentist, or (3) a Non-Delta Dental PPO Dentist who is not a Delta Dental Premier Dentist. See the Schedule of Dental Benefits for a description of the benefit levels for each of the above categories of Dentists.

REQUIRED DOCUMENTATION

The following information must be submitted to DDIL with every request for predetermination of plan benefits or claim for payment for the listed Dental Benefits. In the absence of this information or the requested information indicated on DDIL's claim form, this Group Dental Plan will be unable to render a benefit determination.

Full Mouth Series of Radiographs: This Group Dental Plan requires the submission of full mouth radiographs with every claim for non-surgical periodontics, surgical periodontics and complete dentures.

Full Arch Periapical Radiographs: This Group Dental Plan requires the submission of full arch periapical radiographs with every claim for osseous fractures and fixed partial and removable dentures.

Periapical Radiographs: This Group Dental Plan requires the submission of periapical radiographs with every claim for surgical extractions, endodontics (post-operative radiographs), cast restorations and space maintainers.

Narrative: This Group Dental Plan requires the submission of a narrative with every claim for consultations, emergency examinations, palliative treatment and general anesthesia.

Histopathology/Hospital Report: This Group Dental Plan requires the submission of a histopathology and/or hospital report with every claim for biopsies and the surgical excision of tissue.

GENERAL PROVISIONS

NOTICE AND PROOF OF DENTAL CLAIMS

Written notice and proof of claim is to be furnished to DDIL within 90 days after the Covered Individual has received a Dental Benefit.

Failure to furnish this Proof of Claim within this 90 day time period shall not invalidate or reduce any claim if the Covered Individual provides a reasonable explanation of this failure to file a timely claim. IN NO EVENT WILL EMPLOYER BE LIABLE FOR ANY NOTICE OR PROOF OF CLAIM WHICH IS SUBMITTED TO DDIL MORE THAN ONE YEAR AFTER THE COVERED INDIVIDUAL HAS RECEIVED DENTAL SERVICES FOR THAT CLAIM. No action shall lie against employer unless, as a condition precedent thereto, the Covered Individual shall have fully complied with the notice and Proof of Claim provisions contained in this Dental Benefits Booklet.

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 under this plan exceed the amount which would have been allowed if dental coverage did not exist.

If a Covered Individual is entitled to coverage under two or more policies or prepaid health care plans, then the covered Dental Benefits of this Group Dental Plan shall be paid as follows:

- (a) The benefits of the plan which covers the person directly as the employee and not as a Dependent will be determined before those of the plan which 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 that year; but

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

However, if a plan subject to the rule based on the birthday of the parents as stated above coordinates with an out-of-state plan which has a rule based upon the gender of the parent, and if as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- (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 does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before that entity has that actual knowledge.

But 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 which 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 which 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 which covered an employee for a longer period of time will be determined before those of the plan which covered that person for the shorter period of time.

If this Group Dental Plan provides only secondary coverage, it shall not be obligated to make payment until DDIL receives a copy of the primary carrier'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.

DISPUTED CLAIMS PROCEDURE

Prior Approval of Benefits: This group dental plan *does not require* prior approval of dental services. Nonetheless, a Covered Individual and his/her treating Dentist may request a predetermination of benefits to obtain advance information on the plan's possible coverage of services before they are rendered. Payment, however, is limited to the benefits that are covered under this plan and is subject to any applicable deductible, waiting periods, annual and lifetime coverage limits as well as this plan's payment policies.

Notice of Adverse Benefit Determination: If a claim is denied in whole or in part, DDIL shall notify the enrollee of the denial in writing, by issuing an Explanation of Benefits (sometimes referred to as an adverse benefit determination), within 30 days after the claim is filed, unless special circumstances require an extension of time, not exceeding 15 days, for processing. DDIL will notify the treating Dentist as well by issuing an Explanation of Payment. If an extension is necessary, DDIL shall notify the enrollee and the treating Dentist of the extension and the reason it is necessary within the original 30-day period. If an extension is needed because either the enrollee or the treating Dentist did not submit

information necessary to decide the claim, the notice of extension shall specifically describe the required information. The claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Explanation of Benefits Form: This form includes 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 DDIL's appeal process and the time limits applicable to the process, including a statement of the enrollee's right, if this group dental plan is subject to the federal law known as the Employee Retirement Income Security Act ("ERISA"), 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.

Request for Appeal of Adverse Benefit Determination: If the enrollee disagrees with DDIL's adverse benefit determination, he/she may appeal this determination to the Reevaluation Committee of DDIL within 180 days following receipt of the adverse benefit determination. The appeal must be in writing and must state why it is believed that DDIL's benefit decision was incorrect. The denial notice, as well as any other documents or information bearing on the claim, should accompany the appeal request. The Reevaluation Committee's review of the claim upon appeal will take into account all comments, documents, records or other information submitted by the claimant, regardless of whether such information was submitted or considered in the initial benefit determination.

Upon request, DDIL will provide, free of charge, reasonable access to and copies of all documents, records and other information relevant to the denied claim.

Reevaluation Committee's Review: The review shall be conducted by a person who is neither the individual who made the initial claim denial nor the subordinate of such 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 the 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 claim denial nor the subordinate of such consultant. The Reevaluation Committee shall provide upon request by the claimant the name of any dental consultant whose advice was obtained in connection with the claim denial, whether or not that advice was relied upon in making the initial benefit determination.

Notice of Review Decision: The Reevaluation Committee shall notify the claimant in writing of its decision on the appeal within 60 days of receipt of the request for review.

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

- Through the use of a reference code (numerical code), a statement of the specific reason(s) 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 of charge upon request;
- A statement of the claimant's right, if this group dental plan is subject to the federal law known as the Employee Retirement Income Security Act ("ERISA"), 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;
- 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.

Employer's Review of Claims for Eligibility Reasons: Notwithstanding the above procedures, employer has the right to review and override all claim determinations related to eligibility or loss of eligibility, whether said claims are approved or denied.

CONTINUATION OF COVERAGE RIGHTS (COBRA)

If employer is required to offer continuation of coverage benefits under federal law and regulations, then Enrolled Employees and their Dependents, if covered under this Group Dental Plan, may be eligible to continue coverage at the individual's own expense. The employer is responsible for advising Covered Individuals of their continuation of coverage rights. For more detailed information, see Appendix D.

APPENDIX A
SCHEDULE OF DENTAL BENEFITS

This Group Dental Plan agrees, SUBJECT TO THE EXCLUSIONS, TERMS AND CONDITIONS SET FORTH HEREIN, to pay for those dental services or procedures listed in this Schedule. Benefit payments are subject to any applicable Deductibles, waiting periods and coverage limits listed in the Dental Plan Specifications.

The level of covered benefits paid under this Group Dental Plan depends on whether a Covered Individual goes to a Delta Dental PPO Dentist, a Non-Delta Dental PPO Dentist who is a Delta Dental Premier Dentist, or a Non-Delta Dental PPO Dentist who is not a Delta Dental Premier Dentist. The following outlines the level of Dental Benefits paid.

IF TREATMENT IS RENDERED BY A DELTA DENTAL PPO DENTIST, this Group Dental Plan shall pay the designated co-payment percentage, as set forth in this Schedule, of the fee that the Delta Dental PPO Dentist has agreed to accept as full reimbursement under this Group Dental Plan. Delta Dental PPO Dentists may only bill the Covered Individual the difference between the fee they have agreed to accept as full reimbursement for services rendered and this Group Dental Plan's benefit payment for a covered service.

IF TREATMENT IS RENDERED BY A NON-DELTA DENTAL PPO DENTIST, this Group Dental Plan shall pay the designated co-payment percentage, as set forth in this Schedule, of DDIL's Approved Fee.

- (1) If the Non-Delta Dental PPO Dentist is a Delta Dental Premier Dentist, the Dentist is bound to accept DDIL's Approved Fee as full reimbursement for his/her services after this Group Dental Plan's benefit payment.
- (2) If the Non-Delta Dental PPO Dentist is not a Delta Dental Premier Dentist, the Dentist may bill the patient the difference, if any, between his/her fee and this Group Dental Plan's benefit payment.

The benefits furnished under this Group Dental Plan are limited and defined as set forth in the Schedule of Dental Benefits. A request for predetermination of contract benefits, accompanied by any required documentation, should be submitted to DDIL for payment determination before services are rendered. A determination made by DDIL imposes no restrictions on the method of diagnosis or treatment by a treating dentist and only relates to the level of payment which this Group Dental Plan is required to make.

APPENDIX A
SCHEDULE OF DENTAL BENEFITS

If the co-payment percentage shown is "N/A", that procedure is not covered under this group dental plan.
See Appendix B for exclusions.

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	100%	100%	100%	N	N	N
Comprehensive oral evaluation – new or established patient: <i>once per Dentist.</i>	100%	100%	100%	N	N	N
Detailed and extensive oral evaluation – problem focused, by report: <i>once per Dentist.</i>	100%	100%	100%	N	N	N
Comprehensive periodontal evaluation – new or established patient: <i>once per Dentist.</i>	100%	100%	100%	N	N	N
Periodic oral evaluations: <i>twice per calendar year</i>	100%	100%	100%	N	N	N
Intra-oral – periapical radiographs	100%	100%	100%	N	N	N
Bitewing x-rays (not including vertical bitewings): <i>twice per calendar year</i>	100%	100%	100%	N	N	N
Complete full mouth x-rays: <i>once in a 36-month interval.</i> <i>A full mouth x-ray includes bitewing x-rays. Panoramic x-ray in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth x-ray, is considered a full mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.</i>	100%	100%	100%	N	N	N
Diagnostic casts: <i>when rendered more than 30 days prior to definitive treatment.</i>	50%	50%	50%	Y	Y	Y
Pulp vitality tests: <i>once per visit</i>	100%	100%	100%	N	N	N

If additional detailed or comprehensive oral evaluations are billed by the same Dentist, the level of benefits will be limited to that of a periodic oral evaluation.

Detailed or comprehensive oral evaluations count toward the calendar year maximum of two oral evaluations.

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network

PREVENTIVE SERVICES

Dental prophylaxis (cleaning): <i>twice per calendar year</i>	100%	100%	100%	N	N	N
Topical fluoride applications: <i>once per calendar year, for dependent children under age 19</i>	100%	100%	100%	N	N	N
Space maintainers: <i>once per lifetime for dependent children under age 14.</i>	100%	100%	100%	N	N	N
Recementation of space maintainers: <i>once per calendar year.</i>	100%	100%	100%	N	N	N
Sealants	N/A	N/A	N/A	N/A	N/A	N/A

RESTORATIVE SERVICES

Amalgam and anterior resin-based composite fillings <i>once per surface in a 12-month interval.</i> <i>When a resin filling is placed on a molar or pre-molar (except on the facial surface of a pre-molar), the level of benefits will be limited to that of an amalgam filling.</i>	80%	80%	80%	Y	Y	Y
Onlays (permanent teeth only)	50%	50%	50%	Y	Y	Y
Crowns and ceramic restorations (permanent teeth only)	50%	50%	50%	Y	Y	Y
Recementation of inlays, onlays, partial coverage restorations, cast or prefabricated posts and cores and crowns	50%	50%	50%	Y	Y	Y
Prefabricated stainless steel crowns	80%	80%	80%	Y	Y	Y
Sedative filling	50%	50%	50%	Y	Y	Y
Pin retention	50%	50%	50%	Y	Y	Y
Cast or prefabricated post and core; core build-up	50%	50%	50%	Y	Y	Y
Additional procedures to construct new crown under existing partial denture framework	50%	50%	50%	Y	Y	Y

When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling.

When multiple pins are requested or placed, the level of benefits will be limited to one pin per tooth.

Sedative fillings are a covered Dental Benefit once per tooth per lifetime.

ENDODONTIC SERVICES

Pulpal and root canal therapy	80%	80%	80%	Y	Y	Y
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Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network

When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.

Retreatment of root canal therapy within 24 months of initial treatment is not a covered benefit.

When incomplete endodontic therapy is billed because the patient has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pulpal debridement.

Pulpal therapy (resorbable filling) is a covered Dental Benefit once per tooth per lifetime.

SURGICAL PERIODONTIC SERVICES						
Gingivectomy or gingivoplasty; gingival flap procedure	80%	80%	80%	Y	Y	Y
Clinical crown lengthening - hard tissue	80%	80%	80%	Y	Y	Y
Osseous surgery (including flap entry and closure)	80%	80%	80%	Y	Y	Y
Guided tissue regeneration, per site: <i>only when performed in association with natural teeth</i>	80%	80%	80%	Y	Y	Y
Bone replacement and soft tissue grafts	80%	80%	80%	Y	Y	Y

NON-SURGICAL PERIODONTIC SERVICES						
Periodontal scaling and root planing	80%	80%	80%	Y	Y	Y
Full mouth debridement to enable comprehensive evaluation and diagnosis: <i>once per lifetime</i>	80%	80%	80%	Y	Y	Y
Periodontal maintenance: <i>twice per calendar year</i>	80%	80%	80%	Y	Y	Y

Periodontal therapy includes treatment for diseases of the gums and bone supporting the teeth once per quadrant in any 24-month interval.

REMOVABLE PROSTHODONTIC SERVICES						
Complete and partial dentures	50%	50%	50%	Y	Y	Y
Adjustments to complete and partial dentures	50%	50%	50%	Y	Y	Y
Repairs to complete and partial dentures	50%	50%	50%	Y	Y	Y
Replace missing or broken teeth	50%	50%	50%	Y	Y	Y
Add tooth or clasp to existing partial denture	50%	50%	50%	Y	Y	Y
Replace all teeth and acrylic on cast metal framework	50%	50%	50%	Y	Y	Y
Denture rebase: <i>once in a 24-month interval.</i>	50%	50%	50%	Y	Y	Y
Denture relines: <i>once in a 24-month interval.</i>	50%	50%	50%	Y	Y	Y

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network

FIXED PROSTHODONTIC SERVICES (BRIDGES)						
Pontics	50%	50%	50%	Y	Y	Y
Fixed partial denture retainers - inlays/onlays (inlays/onlays placed as abutments, i.e., to retain or support fixed partial dentures)	50%	50%	50%	Y	Y	Y
Fixed partial denture retainers – crowns (crowns placed as abutments, i.e., to retain or support fixed partial dentures)	50%	50%	50%	Y	Y	Y
Recement fixed partial denture	50%	50%	50%	Y	Y	Y
Cast or prefabricated post and core; core build-up	50%	50%	50%	Y	Y	Y

When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 60 months following placement of the initial appliance is not a covered benefit.

When the edentulous space between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of one pontic per missing tooth.

When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.

If, in the construction of a prosthodontic appliance, personalized or special techniques including, but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontic appliance.

When a porcelain/ceramic inlay is requested or placed as an abutment (i.e., to retain or support a fixed partial denture), the level of benefits will be limited to that of a cast metal inlay.

ORAL SURGERY						
Simple extractions	80%	80%	80%	Y	Y	Y
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	80%	80%	80%	Y	Y	Y
Removal of impacted tooth – soft tissue	100%	100%	100%	N	N	N
Removal of impacted tooth – partially bony	100%	100%	100%	N	N	N
Removal of impacted tooth – completely bony	100%	100%	100%	N	N	N
Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus	80%	80%	80%	Y	Y	Y
Surgical access of an unerupted tooth	80%	80%	80%	Y	Y	Y
Biopsy of oral tissue; brush biopsy	80%	80%	80%	Y	Y	Y
Alveoloplasty - per quadrant	80%	80%	80%	Y	Y	Y
Vestibuloplasty - ridge extension	80%	80%	80%	Y	Y	Y
Surgical excision of soft tissue lesions	80%	80%	80%	Y	Y	Y
Surgical excision of intra-osseous lesions	80%	80%	80%	Y	Y	Y

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network
Other covered surgical/repair procedures: removal of exostosis, torus palatinus or torus mandibularis; incision and drainage of abscess - intraoral soft tissue; frenulectomy or frenuloplasty; excision of hyperplastic tissue or pericoronal gingiva; surgical reduction of osseous or fibrous tuberosity.	80%	80%	80%	Y	Y	Y

Oral Surgery includes extractions and other listed oral surgery procedures (including pre- and post-operative care) only when provided in a dentist's office.

ADJUNCTIVE GENERAL SERVICES						
Palliative (emergency) treatment of dental pain - minor procedure	100%	100%	100%	N	N	N
Deep sedation/general anesthesia: <i>when provided by a dentist in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	80%	80%	80%	Y	Y	Y
Intravenous conscious sedation/analgesia: <i>when provided in conjunction with Oral Surgery (surgical procedures) other than simple extractions.</i>	80%	80%	80%	Y	Y	Y
Consultations	100%	100%	100%	N	N	N

OTHER						
Cephalometric films: <i>with Orthodontic coverage only</i>	50%	50%	50%	Y	Y	Y

ORTHODONTIC SERVICES						
Treatment necessary for the proper alignment of teeth, <i>for all Covered Individuals.</i>	50%	50%	50%	N	N	N

If specialized techniques (for example, clear or "Invisalign" braces) are elected, a Delta Dental PPO dentist is not obligated to accept the scheduled fee as full payment and may charge the patient any difference in cost between the optional method and a conventional appliance in addition to scheduled copayment amounts.

APPENDIX B
EXCLUSIONS

EXCLUSIONS THAT APPLY TO DIAGNOSTIC SERVICES:

- Pulp vitality tests billed in conjunction with any service except for an emergency exam or palliative treatment are not a covered benefit.

EXCLUSIONS THAT APPLY TO PREVENTIVE SERVICES:

- Recementation of a space maintainer within six months of initial placement is not a covered benefit.

EXCLUSIONS THAT APPLY TO RESTORATIVE SERVICES:

- Fillings are not a covered benefit when crowns are allowed for the same teeth.
- Replacement of any existing cast restoration (crowns, onlays, ceramic restorations) with any type of cast restoration within 60 months following initial placement of existing restoration is not a covered benefit.
- Replacement of a stainless steel crown with any type of cast restoration is not a covered benefit by the same office within 24 months following initial placement.
- A cast restoration is a covered benefit only in the presence of radiographic evidence of decay or missing tooth structure. Restorations placed for any other purpose, including, but not limited to, cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformations of teeth, or the anticipation of future fractures, are not a covered benefit.
- When there is radiographic evidence of sufficient vertical height (more than three millimeters above the crestal bone) on a tooth to support a cast restoration, a crown build-up is not a covered benefit.
- The repair of any component of a cast restoration is not a covered benefit.
- Recementation of inlays, onlays, partial coverage restorations, cast and prefabricated posts and cores and crowns by the same office within six months of initial placement is not a covered benefit.
- Additional procedures to construct a new crown under the existing partial denture framework within six months following initial placement is not a covered benefit.
- When a sedative filling is requested or placed on the same date as a permanent filling, the sedative filling is not a covered benefit.

EXCLUSIONS THAT APPLY TO ENDODONTIC SERVICES:

- When a benefit has been issued for endodontic services, retreatment of the same tooth within two years is not a covered benefit.
- Endodontic procedures performed in conjunction with complete removable prosthodontic appliances are not a covered benefit.

EXCLUSIONS THAT APPLY TO PERIODONTIC SERVICES:

- Guided tissue regeneration billed in conjunction with implantology, ridge augmentation/sinus lift, extractions or periradicular surgery/apicoectomy is not a covered benefit.
- Crown lengthening or gingivoplasty, if not performed at least four weeks prior to crown preparation, is not a covered benefit.

- Bone replacement grafts performed in conjunction with extractions or implants are not a covered benefit.
- Periodontal splinting to restore occlusion is not a covered benefit.

EXCLUSIONS THAT APPLY TO PROSTHODONTIC SERVICES:

- Replacement of any existing prosthodontic appliance (cast restorations, fixed partial dentures, removable partial dentures, complete denture) with any prosthodontic appliance within 60 months following initial placement of existing appliance is not a covered benefit.
- When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the fixed partial denture is not a covered benefit.
- Any prosthodontic appliance connected to an implant is not a covered benefit.
- Reline or rebase of an existing appliance within six months following initial placement is not a covered benefit.
- Fixed or removable prosthodontics for a patient under age 16 is not a covered benefit.
- Tissue conditioning is not a covered benefit.
- When the edentulous (toothless) space between teeth is less than 50% of the size of the missing tooth, a pontic is not a covered benefit.

EXCLUSIONS THAT APPLY TO ORAL SURGERY:

- Mobilization of an erupted or malpositioned tooth to aid eruption or placement of a device to facilitate eruption of an impacted tooth performed in conjunction with other oral surgery is not a covered benefit.

GENERAL EXCLUSIONS THAT APPLY TO ALL PROCEDURES:

Coverage is NOT provided for:

- Services compensable under Worker's Compensation or Employer's Liability laws.
- Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges which the person is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its Amendments.
- Services performed to correct developmental malformation including, but not limited to, cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis and congenitally missing teeth. This exclusion does not apply to *newborn infants*.
- Services performed for purely cosmetic purposes, including, but not limited to, tooth-colored veneers, bonding, porcelain restorations and microabrasion. Orthodontic care benefits shall fall within this exclusion unless such benefits are provided by endorsement.
- Charges for services completed prior to the date the person became covered under this program.
- Services for anesthetists or anesthesiologists.
- Temporary procedures.
- Any procedure requested or performed on a tooth when radiographs indicate that less than 40% of the root is supported by bone.

- Services performed on non-functional teeth (second or third molar without an opposing tooth).
- Services performed on deciduous (primary) teeth near exfoliation.
- Drugs or the administration of drugs, except for general anesthesia and intravenous sedation.
- Procedures deemed experimental or investigational by the American Dental Association, for which there is no procedure code, or which are inconsistent with Current Dental Terminology coding and nomenclature.
- Services with respect to any disturbance of the temporomandibular joint (jaw joint).
- Procedures, techniques or materials related to implantology or edentulous (toothless) ridge enhancement.
- Procedures that Delta Dental considers to be included in the fees for other procedures. For such procedures, a separate payment will not be made by this group dental plan. A Dentist in the Delta Dental PPO or Delta Dental Premier network may not bill the patient for such procedures.
- The completion of claim forms and submission of required information, not otherwise covered, for determination of benefits.
- Infection control procedures and fees associated with compliance with Occupational Safety and Health Administration (OSHA) requirements.
- Broken appointments.
- Services and supplies for any illness or injury occurring on or after the *covered individual's effective date of coverage* as a result of war or an act of war.
- Services for, or in connection with, an intentional self-inflicted injury or illness while sane or insane, except when due to domestic violence or a medical (including both physical and mental) health condition.
- Services and supplies received from either a *covered individual's* or *covered individual's* spouse's relative, any individual who ordinarily resides in the *covered individual's* home or any such similar person.
- Services for, or in connection with, an injury or illness arising out of the participation in, or in consequence of having participated in, a riot, insurrection or civil disturbance or the commission of a felony.
- Charges for services for inpatient/outpatient hospitalization.
- Services or supplies for oral hygiene or plaque control programs.
- Services or supplies to correct harmful habits.

**APPENDIX C
DENTAL PLAN SPECIFICATIONS**

CONTRACT NUMBER: 2019

BENEFIT YEAR: January 1st through December 31st

DENTAL BENEFITS BOOKLET REISSUANCE DATE: July 1, 2009

ELIGIBILITY REQUIREMENTS:

All present regular, full-time employees of employer who work a minimum of 30 hours per week and who are eligible for employer's medical plan are eligible for coverage in this Group Dental Plan. Dependent eligibility must match that of employer's medical plan.

All present employees who are not employed full time as of the Group Plan Commencement Date, but subsequently do become full-time employees who are eligible for employer's medical plan, are eligible for coverage in this Group Dental Plan on the date of commencement of full-time status. Dependent eligibility must match that of employer's medical plan.

All future regular, full-time employees who work a minimum of 30 hours per week and who are eligible for employer's medical plan will become eligible on the date of employment and **MUST BE ENROLLED** at that time. Dependent eligibility must match that of employer's medical plan.

An employee's coverage shall terminate on the date s/he is no longer eligible for the employer's medical plan. Coverage of an employee's Dependents also shall terminate at that time.

DEFINITIONS:

"Dependent" means the employee's lawful spouse and unmarried dependent children (see "Dependent children" definition below for age limitations). Children include stepchildren, adopted children and foster children, provided such children are dependent upon the employee for more than one-half of their support. No person may be considered a Dependent of more than one employee.

"Late enrollee" means an employee or Dependent who does not enroll in this Group Dental Plan within 31 days following his/her Eligibility Date.

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 July 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.

DEDUCTIBLE:

Procedures listed in the Schedule of Dental Benefits for which a Deductible applies are subject to a \$25.00 Deductible per Covered Individual per Benefit Period, not to exceed \$75.00 per family unit per Benefit Period.

BENEFIT WAITING PERIODS FOR LATE ENTRANTS:

Late Enrollees must be enrolled in this Group Dental Plan for 12 consecutive months before receiving Dental Benefits for Diagnostic, Preventive, Restorative, Endodontic, Surgical and Non-Surgical Periodontic, Prosthodontic and Adjunctive services, Cast Restorations and Oral Surgery.

Late Enrollees must be enrolled in this Group Dental Plan for 36 consecutive months before receiving orthodontic benefits.

The number of months during which the Late Enrollee was enrolled in employer's prior dental plan will be applied toward satisfying the waiting periods under this Group Dental Plan.

COVERAGE LIMITS:

The maximum coverage limit (excluding orthodontic benefits) per Covered Individual per Benefit Period is \$1500.00.

COVERAGE LIMITS - ORTHODONTIA:

Lifetime orthodontic benefits payable by Delta Dental per Covered Individual shall not exceed \$2000.00. Delta Dental will pay 50 percent of the submitted fee, not to exceed the \$2000.00 lifetime maximum per Covered Individual.

EXTENSION OF BENEFITS:

No benefits will be available for charges incurred after a Covered Individual's coverage terminates, except for covered dental expenses incurred for treatment that was started while the person was covered under this Group Dental Plan and completed within 31 days after the Covered Individual's coverage terminated.

Orthodontic benefits will be payable through the end of the calendar month in which coverage terminated.

A predetermination of plan benefits does not constitute treatment started.

APPENDIX D CONTINUATION OF COVERAGE

This Appendix contains important information about continuation coverage which may be available to Covered Individuals under federal law. 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 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. For example, if your non-disabled child loses status as a full-time student after having attained the limiting age for Dependent coverage, your child no longer qualifies for coverage 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.



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