DELTA DENTAL

Delta Dental of Illinois

Delta Dental PPO[SM]

Certificate of Coverage

Granite City Community Unit School District #9

Group #11641

Effective Date: 07/01/21

DELTA DENTAL OF ILLINOIS
111 Shuman Boulevard
Naperville, Illinois 60563
800-323-1743

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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* in 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. 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 800-323-1743 to speak to a customer service representative for questions concerning eligibility, benefits information, status of your claim, 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.

II: HOW YOUR GROUP DENTAL PLAN WORKS

What You Should Know About Selecting a Dentist

May I go to any Dentist*?*

Yes. You may choose to go to any licensed Dentist whenever you need dental care. Whatever Dentist you choose, you will receive some level of benefits for covered services. However, there are advantages when you receive treatment from a Dentist participating in one of the Delta Dental networks.

How does Delta Dental determine its payment?

Under your group dental plan, the amount Delta Dental uses as the basis for calculating its payment obligation for covered services, what we call the Allowed Amount, is the lesser of the Dentist's Submitted Amount or the Scheduled Fee. Your payment responsibility will depend on who you select as your treating Dentist.

What are the advantages of going to a Dentist who participates in the Delta Dental PPO network?

- Dentists participating in the Delta Dental PPO network are obligated to accept the lesser of the Dentist's Submitted Amount or the Scheduled Fee as full payment for services covered under your group dental plan. That amount is what we refer to as the Approved Amount. For Dentists in the Delta Dental PPO network, the Approved Amount is also the Allowed Amount, the amount Delta Dental uses as the basis for calculating its payment obligation under your group dental plan.

- You are not responsible for charges exceeding the Approved Amount for covered dental services. Any difference between the Dentist's Submitted Amount and the Approved Amount is called the Fee Adjustment, and is money you save. You only are responsible for the applicable Deductible and patient Co-Payment amount. This payment arrangement means that your out-of-pocket costs are likely to be less.

- Delta Dental pays Dentists in the Delta Dental PPO network directly, so you do not have to pay the whole bill up front and wait for reimbursement.

What happens if I choose a Dentist who does not participate in the Delta Dental PPO network?

If you chose a Dentist who participates in the Delta Dental Premier network: If the Dentist you select does not participate in the Delta Dental PPO network, you may still reduce your out-of-pocket costs, if you go to a Dentist who participates in the Delta Dental Premier network. Delta Dental Premier serves as a "safety net" providing out-of-network, out-of-pocket protection for you.

A Dentist *participating in the Delta Dental Premier network* is obligated to accept the lesser of the Dentist's Submitted Amount or the Maximum Plan Allowance as full payment for services covered under your group dental plan. That amount is what we refer to as the Approved Amount. For Delta Dental Premier Dentists, the Approved Amount is also the Allowed Amount, the amount Delta Dental uses as the basis for calculating its payment obligation under your group dental plan. Again, you are only responsible for the applicable Deductible and patient Co-Payment amount. While the Fee Adjustment may not be as great as with Dentists who participate in the Delta Dental PPO network and the patient Co-Payment amount may be somewhat higher, you can still save money. In addition, Delta Dental pays Dentists who participate in the Delta Dental Premier network directly, so you do not have to pay the whole bill up front and wait for reimbursement.

If you choose a Dentist who does not participate in the Delta Dental PPO or Delta Dental Premier networks: If the Dentist you select does not participate in the Delta Dental PPO network or the Delta Dental Premier network, you will be responsible for the difference between your Dentist's Submitted Amount and Delta Dental's payment. The amount Delta Dental uses to calculate its payment, that is the Allowed Amount, will be the lesser of the Dentist's Submitted Amount and Maximum Plan Allowance. Delta Dental has the right to make any benefit payment either to you or directly to the non-Delta Dental (out-of-network) provider. Delta Dental is specifically authorized by you to determine to whom any benefit payment should be made. At the Dentist's discretion, you may have to pay the entire bill in advance.

Depending on the Dentist I choose, what would be an example of my out-of-pocket costs?

If you choose a Dentist in the **Delta Dental PPO** network:

Submitted Amount:	$700
Fee Adjustment:	$200
Approved Amount (Fee Schedule):	$500
Allowed Amount (Fee Schedule):	$500
Deductible Applied:	satisfied
Delta Co-Payment Amount:	50 %
Patient Payment:	$250
Delta Payment:	$250

Because this Dentist has agreed to accept the Scheduled Fee as full payment for covered procedures (Approved Amount), you cannot be charged the $200 difference (Fee Adjustment).

If you choose a Dentist who is not in the **Delta Dental PPO** network, but is participating in the **Delta Dental Premier** network:

Submitted Amount:	$700
Fee Adjustment:	$100
Approved Amount (Maximum Plan Allowance):	$600
Allowed Amount (Maximum Plan Allowance):	$600
Deductible Applied:	satisfied
Delta Co-Payment Amount:	50 %
Patient Payment:	$300
Delta Payment:	$300

Because this Dentist accepted Delta Dental's Maximum Plan Allowance *(*Approved Amount) as payment in full, you cannot be charged the $100 difference (Fee Adjustment).

If you choose a Dentist who does not participate in either the **Delta Dental PPO** network or the **Delta Dental Premier** network:

Submitted Amount:	$700
Fee Adjustment:	$0
Approved Amount (Submitted Amount):	$700
Allowed Amount (Maximum Plan Allowance):	$600
Deductible Applied:	satisfied
Delta Co-Payment Amount:	50 %
Patient Payment	$400
Delta Payment:	$300

Because Dentists who do not participate in the Delta Dental PPO network or the Delta Dental Premier network do not have agreements with Delta Dental, you will be responsible for the difference between Delta Dental's payment and your Dentist's Submitted Amount.

How will I be notified of Delta Dental's payment determination?

You will receive an Explanation of Benefits Statement if you have to pay any portion of the claim, or if payment is issued directly to you for an out-of-network claim. If your payment responsibility is zero and we issue payment directly to the Dentist, you will not receive an Explanation of Benefits Statement because your claim has been paid in full. However, you may still check claim status on our Web site or by using the automated phone system.

How can I find out if my regular Dentist is a participating Dentist in the Delta Dental PPO or Delta Dental Premier networks, or get a list of Dentists near me?

We offer two easy ways to locate a participating 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 800-323-1743.

Using either method, you can request a list of participating Dentists or specialists within a designated area. Participating Dentist information can be obtained for Dentists nationwide. You should keep in mind that there are two categories of participating Dentists: Delta Dental PPO and Delta Dental Premier. We also recommend that you check with your Dentist to confirm whether he or she participates in the Delta Dental PPO network or Delta Dental Premier network.

What You Should Know About Pre-Treatment Estimates

Am I required to submit a Pre-Treatment Estimate before beginning treatment?

Although Pre-Treatment Estimates are not required, **Delta Dental strongly recommends that you ask your Dentist to submit a Pre-Treatment Estimate for treatment costing $200 or more.** The Pre-Treatment Estimate lets you know in advance whether the requested services are covered under your group dental plan. Often patients believe a service is covered if their Dentist provided it. This is not always the case. The benefits of your group dental plan that your Group Subscriber has selected govern what is a covered service.

What does a Pre-Treatment Estimate need to include?

A Pre-Treatment Estimate must describe the procedures and services that the treating Dentist plans to perform, including the actual fees to be charged for each procedure or service. We require the submission of the following for an estimation of your benefits.

Required Documentation	Procedure/Service Planned (or Received)
Full mouth radiographs	Non-surgical and surgical periodontics
Full arch periapical radiographs	Osseous fractures and fixed bridgework
Periapical radiographs	Surgical extractions and cast restorations
Narrative	Consultations, palliative treatment and general anesthesia

Histopathology and/or hospital report	Biopsies and the surgical excision of tissue

What happens after a Pre-Treatment Estimate request is submitted?

We will review the request, along with any required documentation submitted by the treating Dentist. We will then issue a Pre-Treatment Estimate outlining the estimated level of payment under your group dental plan. Please keep in mind that a Pre-Treatment Estimate is only an estimate and not a guarantee of payment. Estimated benefits may be reduced after completion of treatment due to changes in your or your Dependent's eligibility, application of Deductibles and maximum Coverage Limits. In addition, a Pre-Treatment Estimate does not take into consideration other coverage you may have; Delta Dental coordinates benefits after treatment is completed and a claim is submitted for payment. An estimate made by Delta Dental imposes no restrictions on the method of treatment by a Dentist and only relates to the level of payment that we are required to make.

What You Should Know About Filing a Claim

When do I file a claim?

After you receive services, you should file a claim only if your Dentist has not filed one for you. Dentists participating in the Delta Dental PPO and Delta Dental Premier networks automatically submit claim forms on your behalf at no additional charge.

You should file a claim only after the procedure is completely finished. Do not file for payment before a procedure is completed. All clean claims payable for benefits under the group dental plan shall be paid within thirty (30) days after We receive a completed claim form, unless special circumstances require an extension of time for processing. Upon receipt of the necessary information, We will pay claims within thirty (30) days. If We do not pay Your claim within 30 days of receiving all of the necessary information, We will pay You interest at the rate of 9% per year starting from the 30th day following receipt of all the necessary information.

How do I file a claim for payment?

You can complete a claim form and mail it to: Delta Dental of Illinois
P.O. Box 5402
Lisle, IL 60532

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.

What documentation must accompany a claim for payment?

If a Pre-Treatment Estimate is not submitted, we require the submission of the same documentation for a claim for payment as is needed for a Pre-Treatment Estimate. (See the Required Documentation chart under the section entitled *"*What You Should Know About Pre-Treatment Estimates.")

Is there a time limit for submitting dental claims?

Yes, you have one full year from the Date of Service to submit your dental claims.

How are claims filed and payments made for orthodontia treatment?

At the time orthodontia treatment begins, the Dentist generally files a claim for the entire course of orthodontia treatment. Delta Dental then determines the benefits to be paid over the course of treatment and sets up a payment schedule consisting of an initial payment followed by monthly payments for ongoing treatment.

Delta Dental first computes initial and monthly fees based on the Dentist's submitted total case fee and the length of the treatment plan: 25 % of the total case fee is designated as the initial fee, and the remaining 75 % of the total case fee is divided by the number of months of treatment (not to exceed 24 months) to determine the monthly fee. Delta Dental then pays the designated percentage of the initial or monthly fee, up to the Lifetime Maximum benefit for orthodontia, as long as the patient remains eligible for coverage.

Claims & Appeal Procedures

How will I know when my claim is processed?

If your Dentist is paid directly: Unless your payment responsibility is zero, you will receive an Explanation of Benefits that describes the services your Dentist submitted and the benefits that your group dental plan covers. The treating Dentist will receive an Explanation of Payment along with the payment.

Assignment of benefits: Delta Dental will make benefit payments for services rendered by a Dentist who participates in a Delta Dental network directly to that Dentist. For services rendered by a Dentist who does not participate in a Delta Dental network, Delta Dental has the right to make any benefit payment either to the Subscriber or directly to the non-Delta Dental (out-of-network) provider. No provision of the Illinois Insurance Code, or any other law, prohibits an insured from making an assignment of all or any part of his/her rights and

privileges under the policy. Delta Dental is specifically authorized by the Subscriber to determine to whom any benefit payment should be made unless the insured makes a written assignment of benefits.

If you are paid directly: 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.

You can also check claim status on our Web site or by using the automated phone system.

How do I appeal a denied claim?

You may appeal a claim that is denied, 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
111 Shuman Boulevard
Naperville, Illinois 60563

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 the provisions governing claim denials and appeal procedures under your group dental plan.

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.

What services are not covered under this plan?

Not all services that your 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 Dentist states that the treatment is necessary and appropriate. This does not mean that Delta Dental considers more frequent cleanings unnecessary or inappropriate; rather, this is simply a limitation on how often benefits are paid for cleanings under your group dental plan. See Appendix A, Schedule of Dental Benefits, for the applicable payment policies.

What is an alternate benefit provision and how does it work?

There are times when there are multiple ways to treat a dental condition. The payment policies may cover only one way. This does not mean that your Dentist made an inappropriate recommendation. In fact, you may use Delta Dental's payment toward another method of treatment. But since Delta Dental's payment is the same no matter which treatment you choose, you may have higher out-of-pocket expenses if you choose a treatment that costs more.

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

Deductible: This is the fixed dollar amount you pay for covered services in a Benefit Period before we pay benefits under this group dental plan. For the procedures subject to a Deductible, see Appendix A, Schedule of Dental Benefits. For the Deductible amount under your group dental plan, see Appendix C, Dental Plan Specifications. If there is a family Deductible, it is reached from Deductible amounts paid by you and/or any combination of other family members.

Co-Payment: This is the portion of the Allowed Amount, calculated using a fixed percentage that Delta Dental pays for each covered procedure. See Appendix A, Schedule of Dental Benefits, for the Co-Payment that Delta Dental pays. If Delta Dental's Co-Payment is 80%, you would be responsible for 20% of the Allowed Amount.

Coverage Limits: This is the maximum benefit any Covered Individual is eligible to receive for covered procedures in a Benefit Period. See Appendix C, Dental Plan Specifications, for your group dental plan's applicable Coverage Limits.

Lifetime Maximum: Certain dental procedures, if covered under your group dental plan, may be subject to a lifetime fixed dollar amount. Should your group dental plan cover such procedures (for example, orthodontia) there would be a limit on a Covered Individual's lifetime total benefits as shown in Appendix C, Dental Plan Specifications.

What is coordination of benefits?

When you are covered under more than one policy or prepaid health care plan, the benefits under these policies or plans will be coordinated. If your employer's or organization's group dental plan is the primary plan, we will pay our normal benefits as if there is no other coverage. If your employer's or organization's group

dental plan is the secondary plan, we will determine what benefits would have been paid if you didn't have other coverage. We will then pay the balance of the Approved Amount that was not paid by the primary plan, up to what Delta Dental's normal payment would have been if you had no other coverage. The combined payments of all plans will never be more than your actual bill.

See Appendix D for the Coordination of Benefits provisions 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.

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.

If you are eligible for coverage under this group dental plan, your adopted child is eligible from the date of an interim court order for adoption, the date the child is adopted or placed for adoption, or the date of a final order granting adoption, whichever comes first.

Dependents in military service are not eligible for coverage. If your Dependent, while enrolled in this group dental plan, is called to active duty, coverage for that Dependent will terminate on the date of departure for active duty. Upon return to civilian status, your eligible Dependent will be reinstated with coverage on 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. 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, age 26 and older, 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.

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

You may change the type of coverage elected during the Contract Term 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).

- Any other qualifying status change valid under Illinois law.

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 31 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 unit* 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 Contract Term?

Once enrolled in this group dental plan, you and your Dependents must remain enrolled for the duration of the Contract Term 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?

You (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.

* 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.

V: DEFINITIONS

"Allowed Amount" means the amount that the Group Subscriber has contracted with Delta Dental to use for calculating this group dental plan's payment responsibility.

"Approved Amount" means the amount that the Dentist has agreed to accept as full payment for treatment.

"Benefit Period" means the reference period specified in the Schedule of Dental Benefits for purposes of determining the application of Deductibles, waiting periods and Coverage Limits for each Covered Individual.

"Certificate of Coverage" means the subscription certificate issued to a Subscriber by Delta Dental setting forth the terms, conditions, and provisions of this group dental plan. The Group Subscriber shall be responsible for distributing copies of the Certificate of Coverage to Subscribers.

"Civil Union Partner" means an individual of either the same or opposite gender with whom the Subscriber has entered into a legal civil union.

"Contract" means the agreement between Delta Dental and Group Subscriber, including Group Subscriber's application and its attachments and any schedules or subsequent amendments attached hereto. The Contract constitutes the entire agreement between the parties and supersedes all related discussions and other communications between the parties.

"Contract Term" means the period from the Group Subscriber's Effective Date and continuing for the period of time designated herein and each term thereafter during which this group dental plan remains in effect.

"Co-Payment" means the designated portion (fixed percentage) of the Allowed Amount that Delta Dental is contractually obligated to pay for a covered procedure, up to the group dental plan maximum for the patient. The patient Co-Payment is the portion (fixed percentage) of the Allowed Amount remaining after Delta Dental's Co-Payment.

"Coverage Limits" means the maximum benefit any Covered Individual is eligible to receive for covered procedures in a Benefit Period.

"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 herein.

"Date of Service" means the date treatment is COMPLETED for any particular Dental Benefit for the purpose of allocating the particular Dental Benefit to the appropriate Benefit Period and paying claims made under this group dental plan.

"Deductible" means the amount specified in the Dental Plan Specifications which a Covered Individual is required to pay before designated Dental Benefits are payable under this group dental plan.

"Delta Payment" means the amount Delta Dental pays for the services listed on a claim.

"Dental Benefits" means benefits paid for those dental procedures or services covered under this group dental plan and subject to the exclusions, terms, conditions and provisions contained herein.

"Dentist" means an individual licensed to practice dentistry at the time and in the place services are provided.

- **"Dentist participating in the Delta Dental PPO Network"** means a Dentist licensed to practice dentistry and who, by written agreement with Delta Dental of Illinois or another Delta Dental member company, will provide dental services to Covered Individuals in accordance with Delta Dental's Fee Schedules and has agreed to abide by the bylaws, rules and regulations established by Delta Dental.

- **"Dentist participating in the Delta Dental Premier Network"** means a Dentist licensed to practice dentistry and who, by written agreement with Delta Dental of Illinois or another Delta Dental member company, undertakes to provide dental services to Covered Individuals in accordance with the terms and conditions established by Delta Dental and to abide by the by-laws, rules and regulations established by Delta Dental.

- **"Dentist not participating in a Delta Dental network"** means a Dentist who has not agreed to be either a Delta Dental PPO Dentist or a Delta Dental Premier Dentist.

"Dependent" means the Subscriber's spouse under federal or Illinois law, Civil Union Partner, Domestic Partner, and eligible children (including stepchildren, adopted children, foster children, children for whom the Subscriber is a legal guardian and children of a spouse, Civil Union Partner, or Domestic Partner). For age limitations and other eligibility requirements for Dependent children, see the Dental Plan Specifications.

"Domestic Partner" means an individual with whom the Subscriber; is in a relationship which meets the following criteria:

a. The individual must be at least 18 years of age or older;
b. The individual is not married, by statute or common law, Civil Union or in a Domestic Partnership with anyone other than the Subscriber;
c. The individual is not related to the Subscriber; to a degree of closeness that would prohibit legal marriage between opposite or same sex partners in the state in which both parties reside
d. The individual lives in the same residence with the Subscriber;
e. The individual is in an exclusive, committed relationship with the Subscriber; that is intended to be permanent and where both parties have agreed to be mutually responsible for each other's common welfare; and
f. The individual has been in the current relationship for a period of at least 12 months.
g. The individual provides a Domestic Partnership Certificate or Affidavit to the Group Subscriber
h. Domestic Partnership is a legal relationship between 2 persons, of either the same or opposite sex with all of the obligations, protections, and legal rights that state law provides to married heterosexual couples.

"Family Coverage" means coverage for a Subscriber plus a spouse and/or one or more Dependent children.

"Fee Adjustment" means the difference, if any, between the Submitted Amount and the Approved Amount.

Fee Schedule or Scheduled Fee" means the amount that a Dentist in the Delta Dental PPO network agrees contractually to accept as full payment for covered procedures. The Fee Schedule for covered procedures is listed in a table provided to Dentists who participate in the Delta Dental PPO network.

"Group Subscriber" means that particular employing individual, agency, corporation, partnership, 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 this group dental plan.

"Lifetime Maximum" means the maximum lifetime total benefits (fixed dollar amount) for designated covered procedures.

"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.

"Patient Payment" means the amount the patient is obligated to pay the Dentist for the service(s) listed on a claim. The Patient Payment shown on an Explanation of Benefits (EOB) represents the amount the patient is obligated to pay based on the Delta Dental group dental plan Contract. The Patient Payment may be different than what is shown on the EOB if the Covered Individual also has coverage under another plan.

"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.

"Premium" means the rate payable under this Delta Dental group dental plan.

"Pre-Treatment Estimate" means an estimate of the coverage afforded under this group dental plan for Dental Benefits prior to such services being rendered.

"Retiree" means a person retired from the active service of the employer who was covered under this Group Dental Plan immediately prior to retirement.

"Submitted Amount" means the amount billed or charged by the Dentist on a submitted claim.

"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
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.

	Co-Payment Percentage			Deductible Applies		
Procedure	**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%	90%	N	N	N
Comprehensive oral evaluation – new or established patient: *once per Dentist.*	100%	100%	90%	N	N	N
Detailed and extensive oral evaluation – problem focused, by report: *once per Dentist.*	100%	100%	90%	N	N	N
Comprehensive periodontal evaluation – new or established patient: *once per Dentist.*	100%	100%	90%	N	N	N
Periodic oral evaluations: *twice per benefit year*	100%	100%	90%	N	N	N
Intra-oral – periapical radiographs	100%	100%	90%	N	N	N
Bitewing x-rays: *twice per benefit year*	100%	100%	90%	N	N	N
Complete full mouth x-rays: *once in a 36-month interval.* *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 or one panoramic x-ray is a covered benefit in a 36-month interval.*	100%	100%	90%	N	N	N
Diagnostic casts: *when rendered more than 30 days prior to definitive treatment*.	100%	100%	90%	N	N	N
Pulp vitality tests: *once per visit*	100%	100%	90%	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 benefit 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): *twice per benefit year**	100%	100%	90%	N	N	N
Topical fluoride applications: *twice per benefit year, for dependent children under age 19*	100%	100%	90%	N	N	N
Space maintainers: *once per lifetime for dependent children under age 14.*	100%	100%	90%	N	N	N
Recementation of space maintainers: *once per lifetime for dependent children under age 14.*	100%	100%	90%	N	N	N
Sealants: *applied once per tooth to first and second permanent molars which are free of caries (cavities) and restorations; for dependent children under age 16*	80%	80%	70%	Y	Y	Y

**With an indicator for diabetes, high risk cardiac conditions, kidney failure or dialysis conditions, or special healthcare needs, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year.*
**With an indicator for periodontal disease, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.*
**With an indicator for suppressed immune system conditions or cancer-related chemotherapy and/or radiation, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.*
**With an indicator for pregnancy, the enrollee will be eligible for one additional cleaning (prophylaxis or periodontal maintenance) during the time of pregnancy.*

RESTORATIVE SERVICES						
Amalgam and resin-based composite fillings *once per surface in a 12-month interval*.	80%	80%	70%	Y	Y	Y
Onlays (permanent teeth only)	50%	50%	40%	Y	Y	Y
Crowns and ceramic restorations (permanent teeth only)	50%	50%	40%	Y	Y	Y
Recementation of inlays, onlays, partial coverage restorations, cast or prefabricated posts and cores and crowns	50%	50%	40%	Y	Y	Y
Prefabricated stainless steel crowns	50%	50%	40%	Y	Y	Y
Sedative filling	50%	50%	40%	Y	Y	Y
Pin retention	50%	50%	40%	Y	Y	Y
Cast or prefabricated post and core; core build-up	50%	50%	40%	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.

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network
ENDODONTIC SERVICES						
Pulpal and root canal therapy	80%	80%	70%	Y	Y	Y

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	50%	50%	40%	Y	Y	Y
Clinical crown lengthening - hard tissue	50%	50%	40%	Y	Y	Y
Osseous surgery (including flap entry and closure)	50%	50%	40%	Y	Y	Y
Guided tissue regeneration, per site	50%	50%	40%	Y	Y	Y
Bone replacement and soft tissue grafts	50%	50%	40%	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.

Surgical Periodontic Services are only covered when performed in association with natural teeth.

NON-SURGICAL PERIODONTIC SERVICES						
Periodontal scaling and root planing	80%	80%	70%	Y	Y	Y
Full mouth debridement to enable comprehensive evaluation and diagnosis: *once per lifetime*	80%	80%	70%	Y	Y	Y
Periodontal maintenance: *twice per benefit year**	80%	80%	70%	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.

**With an indicator for diabetes, high risk cardiac conditions, kidney failure or dialysis conditions, or special healthcare needs, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year.*
**With an indicator for periodontal disease, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.*
**With an indicator for suppressed immune system conditions or cancer-related chemotherapy and/or radiation, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.*
**With an indicator for pregnancy, the enrollee will be eligible for one additional cleaning (prophylaxis or periodontal maintenance) during the time of pregnancy.*

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network
REMOVABLE PROSTHODONTIC SERVICES						
Complete and partial dentures	50%	50%	40%	Y	Y	Y
Adjustments to complete and partial dentures *twice every 12-months*	50%	50%	40%	Y	Y	Y
Repairs to complete and partial dentures *once every 24-months*	50%	50%	40%	Y	Y	Y
Replace missing or broken teeth	50%	50%	40%	Y	Y	Y
Add tooth or clasp to existing partial denture *once per lifetime*	50%	50%	40%	Y	Y	Y
Replace all teeth and acrylic on cast metal framework *once per lifetime*	50%	50%	40%	Y	Y	Y
Denture rebase: *once in a 24-month interval.*	50%	50%	40%	Y	Y	Y
Denture reline: *once in a 24-month interval.*	50%	50%	40%	Y	Y	Y
FIXED PROSTHODONTIC SERVICES (BRIDGES)						
Pontics	50%	50%	40%	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%	40%	Y	Y	Y
Fixed partial denture retainers – crowns (crowns placed as abutments, i.e., to retain or support fixed partial dentures)	50%	50%	40%	Y	Y	Y
Recement fixed partial denture *once per lifetime*	50%	50%	40%	Y	Y	Y
Cast or prefabricated post and core; core build-up	50%	50%	40%	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 84 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.

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network
ORAL SURGERY						
Simple extractions	80%	80%	70%	Y	Y	Y
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	80%	80%	70%	Y	Y	Y
Removal of impacted tooth – soft tissue	80%	80%	70%	Y	Y	Y
Removal of impacted tooth – partially bony	80%	80%	70%	Y	Y	Y
Removal of impacted tooth – completely bony	80%	80%	70%	Y	Y	Y
Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus	80%	80%	70%	Y	Y	Y
Surgical access of an unerupted tooth	80%	80%	70%	Y	Y	Y
Biopsy of oral tissue; brush biopsy	80%	80%	70%	Y	Y	Y
Alveoloplasty - per quadrant	80%	80%	70%	Y	Y	Y
Surgical excision of soft tissue lesions	80%	80%	70%	Y	Y	Y
Surgical excision of intra-osseous lesions	80%	80%	70%	Y	Y	Y
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%	70%	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%	90%	N	N	N
Deep sedation/general anesthesia: *when provided by a dentist in conjunction with Oral Surgery (surgical procedures) other than simple extractions.*	80%	80%	70%	Y	Y	Y
Intravenous conscious sedation/analgesia: *when provided in conjunction with Oral Surgery (surgical procedures) other than simple extractions.*	N/A	N/A	N/A	N/A	N/A	N/A
Consultations	100%	100%	90%	N	N	N
Athletic mouthguard *once every 24-months for dependent children under age 19*	50%	50%	40%	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						
Implants *once every 7-years for a patient age 16 and older*	50%	50%	40%	Y	Y	Y
ORTHODONTIC SERVICES						
Treatment necessary for the proper alignment of teeth, *for dependent children under age 19*.	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.

- Panoramic x-ray for a patient under age 6 is 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 84 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.

- Major restoratives for a patient under age 12 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 84 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.

- 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 and a Subscriber elects Family Unit coverage. In no event will a Covered Individual age 19 or over be able to receive orthodontic care benefits.

- 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.

- 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 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: 11641

BENEFIT PERIOD: January 1st through December 31st

ELIGIBILITY REQUIREMENTS:

All present regular, full-time employees, as determined by the Employer, 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 first of the month following the first day of full-time employment.

All future regular, full-time employees, as determined by the Employer, become eligible on the first of the month following the first day of employment.

Civil Union Partners, as defined in the Contract/Certificate, and their eligible Dependents are eligible for coverage under this group dental plan.

Domestic Partners, as defined in the Contract/Certificate, and their eligible Dependents are eligible for coverage under this group dental plan.

Retirees, as defined herein, and their eligible Dependents are eligible for coverage under this group dental plan.

DEPENDENT CHILDREN

"Dependent children" means those children who are:

- under the age of 26 regardless of their place of residence, marital status or student status; or
- unmarried children age 26 up to 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 DD 214, Certificate of Release or Discharge from Active Duty) is required.

Coverage for Dependent children terminates the last day of the month in which they attain 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.

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 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.

DEDUCTIBLE:

Procedures listed in the Schedule of Dental Benefits for which a Deductible applies are subject to a $50.00 Deductible per Covered Individual per Benefit Period, not to exceed $150.00 per family unit per Benefit Period.

COVERAGE LIMITS:

IF TREATMENT IS RENDERED BY A DELTA DENTAL PPO DENTIST, the maximum coverage limit (excluding orthodontic benefits) per Covered Individual per Benefit Period is $1,500.00.

IF TREATMENT IS RENDERED BY A DELTA DENTAL PREMIER OR OUT-OF-NETWORK DENTIST, the maximum coverage limit (excluding orthodontic benefits) per Covered Individual per Benefit Period is $1,000.00.

*In the event that some services are provided by a Delta Dental PPO Dentist and others by a Delta Dental Premier and/or out-of-network Dentist, this group dental plan will only make payment as follows:

1. The combined services cannot exceed the maximum coverage limit (excluding orthodontic benefits) of $1,500.00 per Covered Individual per Benefit Period.

2. Once an individual has exhausted $1,000.00 of benefits, the remaining $500.00 must be for treatment with a Delta Dental PPO Dentist.

COVERAGE LIMITS - ORTHODONTIA:

Lifetime orthodontic benefits payable by Delta Dental per Dependent child under age 19 shall not exceed $1,000.00. Delta Dental will pay 50 percent of the Submitted Amount, not to exceed the $1,000.00 Lifetime Maximum per Dependent child under age 19.

ENHANCED BENEFITS PROGRAM:

Procedures listed in the Schedule of Dental Benefits with a single asterisk (*) are part of the Enhanced Benefits Program. Coverage will be at the group-contracted benefit level, with the additional frequency allowance being the only change. There is no age requirement, and the patient may be the Subscriber, or other covered Dependents.

Those eligible for the Enhanced Benefits Program include the following:

- People with periodontal (gum) disease
- People with diabetes
- Pregnant women
- People with high-risk cardiac conditions
- People with kidney failure or who are undergoing dialysis
- People undergoing cancer-related chemotherapy and/or radiation
- People with suppressed immune systems due to HIV positive status, organ transplant, and/or stem cell (bone marrow) transplant
- People with special healthcare needs

If one of these conditions applies to you, sign up for enhanced benefits today by visiting the Subscriber section of www.deltadentalil.com or calling 800-323-1743.

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.

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 payable under this plan when added to the benefits under other plans shall not exceed the *dentist's* total billed fees.

APPENDIX E
APPEALING A CLAIM DENIAL

Notice of a Claim Denial

If you make a claim for benefits under this group dental plan or request a predetermination of benefits and your claim or predetermination request is denied, 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, including a reference to the 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, protocol or other similar criterion that was relied upon in making the adverse benefit 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.

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 these internal claims procedures.

Request for Appeal of Adverse Benefit Determination: To appeal a denied claim, 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 denying your claim. The written appeal must state why you believe that Delta Dental's decision denying your claim was incorrect. You will be provided an opportunity to submit written comments, documents, records, or other information related to the claim. The denial notice, as well as any other written comments, documents or other information relating to the 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 claim for benefits.

You should address your appeal as follows:

Delta Dental of Illinois
Attention: Reevaluation Committee
P.O. Box 5402
Lisle, Illinois 60532

Reevaluation Committee's Review: The Reevaluation Committee's review of the 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 claim denial nor a subordinate of that individual. If the review is of an adverse benefit determination based, on a determination related to dental necessity, experimental treatment or a clinical judgment in applying the terms of your group dental plan, 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 your request, 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 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 a reference to the 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;

- 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, protocol or other similar criterion that was 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.

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