

ESCAMBIA COUNTY BOARD OF COUNTY COMMISSIONERS

Low Plan



deltadentalins.com

Group No. 01440

Effective Date: October 1, 2013

**DENTAL PLAN COVERAGE
FOR YOUR GROUP DENTAL PROGRAM**

This plan is self-funded by your employer.

This booklet is a summary of your group dental program. Please read it carefully. It only summarizes the detailed provisions of the group dental contract issued by **Delta Dental Insurance Company** (“**Delta Dental**”) and cannot modify the Contract in any way.

Claims Administered by:



Delta Dental Insurance Company
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GROUP HIGHLIGHTS

PLAN:

You have a Calendar Year plan and deductibles and maximums will be based upon a Calendar Year, which is January 1st through December 31st.

BENEFITS:	<i>In-Network</i>	<i>Out-of-Network</i>
Diagnostic and Preventive Benefits:	100%	100%
Basic Benefits:	80%	80%
Major Benefits:	50%	50%
Orthodontic Benefits:	50%	50%

DEDUCTIBLE:

For each Enrollee per Calendar Year is \$75.

For all family members per Calendar Year is \$150.

The deductible does not apply to Diagnostic and Preventive Benefits or Orthodontic Benefits.

MAXIMUM:

- The maximum payable each Calendar Year for Benefits is \$1,000 per Enrollee. Diagnostic & Preventive Benefits are not subject to the Calendar Year Maximum Amount.
- The maximum lifetime amount per Enrollee for Orthodontic Benefits is \$500.

Maximum Orthodontic Takeover Credit:

Delta Dental will receive credit for any amounts paid under the Contractholder's previous dental care contract, if applicable, for Orthodontic Benefits. These amounts will be credited towards the maximum amounts payable for Orthodontic Benefits.

COST OF COVERAGE:

You are not required to contribute towards the cost of your coverage.

You are required to contribute towards the cost of your Dependent's coverage.

Delta Dental may cancel this program 31 days after written notice to the Contractholder if the cost of coverage is not paid when due.

DEFINITIONS

Terms when capitalized in this document have defined meanings, given in the section below or throughout the booklet sections.

Approved Amount -- the maximum amount a Dentist may charge for a Single Procedure.

Benefits (In-Network or Out-of-Network) -- the amounts that Delta Dental will pay for dental services under the Contract. In-Network Benefits are those covered by the Contract and performed by a Delta Dental PPO Dentist. Out-of-Network Benefits are those covered by the Contract but performed by a Delta Dental Premier[®] Dentist or Non-Delta Dental Dentist.

Claim Form -- the standard form used to file a claim or request Pre-Treatment Estimate for treatment.

Contract -- the written agreement under which Benefits are provided.

Contract Allowance -- the maximum amount Delta Dental will use for calculating the Benefits for a Single Procedure. The Contract Allowance for services provided:

- by Delta Dental PPOSM Dentists is the lesser of the Dentist's submitted fee, the Delta Dental PPO Dentist's Fee or the Dentist's filed fee with Delta Dental in the Participating Dentist Agreement.
- by Delta Dental Premier Dentists (who are not PPO Dentists) is the lesser of the Dentist's submitted fee, the Dentist's filed fee with Delta Dental in the Participating Dentist Agreement or the Maximum Plan Allowance; or
- by Non-Delta Dental Dentists is the lesser of the Dentist's submitted fee or the Maximum Plan Allowance.

Contractholder -- the employer, union or other organization or group contracting to obtain Benefits.

Delta Dental PPO Dentist (PPO Dentist) -- a participating Delta Dental Dentist who agrees to accept Delta Dental's PPO Dentist's Fees as payment in full and to comply with Delta Dental's administrative guidelines. All PPO Dentists are also Delta Dental Premier Dentists. All PPO Dentists must be contracted in the Delta Dental Premier network.

Delta Dental's PPO Dentist's Fee (PPO Dentist's Fee) -- the fee outlined in the PPO Dentist Agreement. PPO Dentists agree to charge no more than this fee for treating PPO enrollees.

Delta Dental Premier[®] Dentist (Premier Dentist) -- a Dentist who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and who agrees to abide by certain administrative guidelines. Not all Premier Dentists are PPO Dentists; however, all Premier Dentists agree to accept Delta Dental's Maximum Plan Allowance for each Single Procedure as payment in full.

Dentist -- a person licensed to practice dentistry when and where services are performed.

Dependent Enrollee -- a dependent of a Primary Enrollee who is eligible for Benefits under the Contract.

Effective Date -- the date the program starts. This date is given on the booklet cover.

Enrollee -- a Primary Enrollee or Dependent Enrollee enrolled to receive Benefits.

Maximum Plan Allowance (MPA) -- the maximum amount Delta Dental will reimburse for a covered procedure. Delta Dental establishes the MPA for each procedure through a review of proprietary filed fee data and actual submitted claims. MPAs are set annually to reflect charges based on actual submitted claims from providers in the same geographical area with similar professional standing. The MPA may vary by the type of participating Dentist.

Non-Delta Dental Dentist -- a Dentist who is neither a Premier nor a PPO Dentist and who is not contractually bound to abide by Delta Dental's administrative guidelines.

Open Enrollment Period -- the month of the year during which employees may change coverage for the next Contract Year.

Participating PPO Dentist Agreement (PPO Dentist Agreement) -- an agreement between a member of the Delta Dental Plans Association and a Dentist which establishes the terms and conditions under which covered services are provided under a PPO program.

Participating Dentist Agreement -- an agreement between a member of the Delta Dental Plans Association and a Dentist that establishes the terms and conditions under which services are provided.

Pre-Treatment Estimate -- an estimation of the allowable Benefits under the Contract for the services proposed, assuming the patient is eligible.

Primary Enrollee -- any employee or retiree eligible for Benefits under the Contract.

Procedure Code -- the Current Dental Terminology (CDT) number assigned to a Single Procedure by the American Dental Association.

Qualifying Status Change -- a change in:

- legal marital status (marriage, divorce, annulment or death);
- number of dependents (a child's birth, adoption of a child, Eligible Person becomes party in a suit to adopt a child, addition of a step or foster child or eligible grandchild or death of a child);
- employment status (change in employment status of Enrollee, spouse or dependent child);
- dependent child ceases to satisfy eligibility requirements (limiting age, student status or marital status);
- residence (Enrollee, dependent spouse or child moves);
- a court order requiring dependent coverage; or
- any other current or future election changes permitted by IRC Section 125.

Single Procedure -- a dental procedure that is assigned a separate CDT number.

CHOICE OF DENTIST

Delta Dental offers a choice of selecting a Dentist from our panel of PPO Dentists and Premier Dentists, or you may choose a Non-Delta Dental Dentist. A list of Delta Dental Dentists can be obtained by accessing the Delta Dental National Dentist Directory at deltadentalins.com. You are responsible for verifying whether the Dentist you select is a PPO Dentist or a Premier Dentist. Dentists are regularly added to the panel. Additionally, you should always confirm with the dentist's office that a listed Dentist is still a contracted PPO Dentist or a Premier Dentist.

PPO Dentist

The PPO program potentially allows you the greatest reduction in your out-of-pocket expenses, since this select group of Dentists in your area will provide dental Benefits at a charge which has been contractually agreed upon between Delta Dental and the PPO Dentist.

Premier Dentist

The Premier Dentist, which include specialists (endodontists, periodontists or oral surgeons), has not agreed to the features of the PPO program; however, you may still receive dental care at a lower cost than if you use a Non-Delta Dental Dentist.

Non-Delta Dental Dentist

If a Dentist is a Non-Delta Dental Dentist, the amount charged to you may be above that accepted by the PPO or Premier Dentists. Non-Delta Dental Dentists can balance bill for the difference between the MPA and the Non-Delta Dental Dentist's Approved Amount. For a Non-Delta Dental Dentist, the Approved Amount is the dentist's submitted charge.

Additional advantages of using a PPO Dentist or Premier Dentist

- The PPO Dentist and Premier Dentist must accept assignment of Benefits, meaning PPO Dentists and Premier Dentists will be paid directly by Delta Dental after satisfaction of the deductible and coinsurance, and the Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The PPO Dentist and Premier Dentist will complete the dental claim form and submit it to Delta Dental for reimbursement.

WHO IS ELIGIBLE?

Eligibility for Enrollment

All retired employees, present, permanent employees are eligible on the Effective Date.

All future permanent employees working 30 hours per week shall become eligible on the 1st day of the month following 30 days of continuous employment.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents. Dependents are:

- a) The employee's lawful spouse;
- b) Unmarried children from birth to the end of the Calendar Year in which occurs their 25th birthday. "Children" include your natural children, step-children, adopted children, foster children and newborn children of a covered family member. Children must be dependent on you for support. Newborn children will be covered from the moment of birth. An adopted child will be covered from the moment of placement with the Eligible Employee, as certified by the agency making the placement. Eligibility for coverage for a new born child of a covered family member terminates eighteen (18) months after the birth of the newborn.

An unmarried child 25 years or older may continue to be eligible as a dependent if he cannot support himself because of physical handicap or mental incapacity that began before age 25, and the child is mostly dependent on you for support and maintenance. Notification of this dependent status prior to age 25 is not required. Proof of incapacity shall not be required until a claim has been denied due to a child having reached age 25. Proof of these facts must be given to Delta Dental or your employer within thirty-one (31) days if it is requested. Proof will not be required more than once a year after the child is 27.

Dependents in military service are not eligible.

Enrollment Requirements

If you are paying all or a portion of the cost of coverage for yourself or your dependents then:

- You must enroll within 31 days after the date you become eligible or during an Open Enrollment Period.
- All dependents must be enrolled within 31 days after they become eligible or during an Open Enrollment Period.
- If you elect dependent coverage, you must enroll all of your Dependent Enrollees who are not covered under another group plan for coverage.
- If your coverage is dropped other than during an Open Enrollment Period or because of a Qualifying Status Change, you may not re-enroll except during an Open Enrollment Period.
- If you pay the cost of coverage for Dependent Enrollees in the manner elected by the Contractholder and approved by Delta Dental until your dependents are no longer eligible or until you choose to drop dependent coverage and if coverage is dropped other than during an Open Enrollment Period, your dependents may not be re-enrolled at any time, unless there is a court order requiring dependent coverage.
- If both you and your spouse are eligible persons, one of you may enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only one Primary Enrollee.
- A child who is eligible as a Primary Enrollee and a dependent can be insured under the Contract as a Primary Enrollee or as a Dependent Enrollee but not both at the same time.

Loss of Eligibility

Your coverage ends at the end of the month for which the event (Lay-off/reduction of work force/reduce work hours/resignation/termination) happens, or immediately when this program ends. Your dependents' coverage ends when your coverage ends, or as soon as they are no longer dependents as defined in this booklet.

Continuation of Benefits

Delta Dental will not pay for Benefits for any services received after your coverage ends, but Delta Dental will pay for a Single Procedure incurred when the patient was covered if such procedure is completed within 31 days of the date coverage ends. A dental service is incurred as follows:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

Strike, Lay-off and Leave of Absence

You and your dependents will not be covered for any dental services received while you are on strike, lay-off or leave of absence, other than as required under the Family & Medical Leave Act of 1993*.

Benefits for you and your Dependent Enrollees will resume as follows:

- if coverage is reactivated in the same Calendar Year, deductibles and maximums will resume as if you were never gone; or
- if coverage is reactivated in a different Calendar Year, new deductibles and maximums will apply.

Coverage will resume the first day of the month after you return to work, provided you submit to Delta Dental an enrollment card requesting that coverage be reactivated.

*You and your dependents' coverage is not affected if you take a leave of absence allowed under the Family & Medical Leave Act of 1993. If you are currently paying any part of your cost of coverage, you may choose to continue coverage. If you do not continue coverage during the leave, you can resume that coverage on your return to active work as if no interruption occurred. **Important:** The Family & Medical Leave Act does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

If you are rehired within the same Calendar Year, deductibles and maximums will resume as if you were never gone.

Continued Coverage Under USERRA

As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if you are covered by the Contract on the date your USERRA leave of absence begins, you may continue dental coverage for yourself and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of: 24 months beginning on the date the leave of absence begins or the date you fail to return to work within the time required by USERRA. For USERRA leave that extends beyond 31 days, the cost of coverage for continuation of coverage will be the same as for COBRA coverage.

Continuation of Coverage Under COBRA

COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) provides a way for employees and their Dependent Enrollees who lose employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

DEDUCTIBLE

Your dental plan features a deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The deductible amounts are listed on the Group Highlights page.

Only the Dentist's fees you pay for covered Benefits will count toward the deductible, but you do not have to pay a deductible for Diagnostic and Preventive Benefits or Orthodontic Benefits.

MAXIMUM AMOUNT

The Maximum Amount payable is shown on the Group Highlights page. There may be maximums on a yearly basis, a per services basis, or a lifetime basis.

However, Orthodontic Benefits, if provided, will end with the next payment due although the maximum has not been reached if the patient loses coverage, if treatment is stopped, or if the Contract with your employer is canceled.

BENEFITS, LIMITATIONS & EXCLUSIONS

Delta Dental will pay the Benefits for the types of dental services as described below. Delta Dental will pay Benefits only for covered services. These services must be provided by a Dentist and must be necessary and customary under generally accepted dental practice standards. Delta Dental may use dental consultants to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices. If you receive dental services from a Dentist outside the state of Florida, the Dentist will be reimbursed according to Delta Dental's network payment provisions for said state according to the terms of the Contract.

If a comprehensive dental procedure includes component or interim procedures that are performed at the same time as the comprehensive procedure, the component or interim procedures are considered to be part of the comprehensive procedure for purposes of determining the benefit payable under the Contract. If the Dentist bills separately for the comprehensive procedure and each of its component or interim parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the comprehensive procedure.

Enrollee Coinsurance

Delta Dental's provision of Benefits is limited to the applicable percentage of Dentist's fees shown on the Group Highlights page. You are responsible for paying the remaining applicable percentage of any such fees, known as the "Enrollee Coinsurance". Your group has chosen to require Enrollee Coinsurances under this program as a method of sharing the costs of providing dental Benefits between Contractholder and Enrollees.

If the Dentist discounts, waives or rebates any portion of the Enrollee Coinsurance to the Enrollee, Delta Dental will be obligated to provide as Benefits only the applicable percentages of the Dentist's fees reduced by the amount of such fees that is discounted, waived or rebated.

BENEFITS

Delta Dental will pay or otherwise discharge the percentage of Contract Allowance shown on the Group Highlights page for the following covered services.

Diagnostic and Preventive Benefits:

- Diagnostic: procedures to assist the Dentist in choosing required dental treatment.
- Preventive: prophylaxis (cleaning, periodontal cleaning in the presence of gingival inflammation is considered to be periodontal (a Basic Benefit) for payment purposes), topical application of fluoride solutions and space maintainers.

Basic Benefits:

- Oral Surgery: extractions and other surgical procedures (including pre-and post-operative care).
- General Anesthesia: when administered by a Dentist for a covered oral surgery procedure.
- Endodontics: treatment of the tooth pulp.
- Periodontics: treatment of gums and bones supporting teeth.
- Palliative: treatment to relieve pain.
- Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
- Restorative: amalgam, synthetic porcelain, plastic restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
- Denture Repairs: repair to partial or complete dentures including rebase procedures and relining.

Major Benefits:

- Crowns, Inlays/Onlays and Cast Restorations: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain, plastic restorations.
- Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges.

Orthodontic Benefits:

Procedures performed by a Dentist, involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of malalignment of teeth and/or jaws which significantly interferes with their functions.

Note on additional benefits during pregnancy - When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under this Contract include: one (1) additional oral exam and either one (1) additional routine cleaning or one (1) additional periodontal scaling and root planing per quadrant. Written confirmation of the pregnancy must be provided by the Enrollee or her dentist when the claim is submitted.

LIMITATIONS

Limitations on Diagnostic and Preventive Benefits:

- Routine oral examinations and cleanings (including periodontal cleanings) are provided no more than two (2) times in any Calendar Year while the patient is an Enrollee under any Delta Dental or dental care program provided by the Contractholder. Note that periodontal cleanings are covered as a Basic Benefit and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional benefits during pregnancy.
- Full-mouth x-rays or panoramic x-rays will be provided by the Dentist when required, but Delta Dental will only pay for these services once every five (5) years under any Delta Dental program.
- Bitewing x-rays are provided once each Calendar Year for you and your spouse and twice in a Calendar Year for your Dependent Child Enrollees.
- Topical application of fluoride solutions is limited to Enrollees under age 19.
- Space maintainers are limited to the initial appliance only and to Enrollees under age 14.

Limitations on Basic Benefits:

- Sealants are limited as follows:
 - (1) to permanent first molars through age eight (8) and to permanent second molars through age 15 if they are without cavities or restorations on the occlusal surface.
 - (2) Sealants do not include repair or replacement of a sealant on any tooth within two (2) years of its application.
- Delta Dental will not pay to replace an amalgam, synthetic porcelain or plastic fillings or prefabricated stainless steel restorations within 24 months of treatment if the service is provided by the same Dentist.
- Delta Dental limits payment for stainless steel crowns under this section to services on baby teeth. However, after consultant's review, Delta Dental may allow stainless steel crowns on permanent teeth as a Major Benefit.
- Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional benefits during pregnancy.

Limitations on Major Benefits:

- Delta Dental will not pay to replace any crowns, inlays/onlays, or cast restorations which the Enrollee received in the previous five (5) years under any Delta Dental program or any program of the Contractholder.
- Prosthodontic appliances that were provided under any Delta Dental program will be replaced only after five (5) years have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory.
- Delta Dental limits payment for dentures to a standard partial or denture (coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
- Delta Dental will not pay for implants (artificial teeth implanted into or on bone or gums), their removal or other associated procedures, but Delta Dental will credit the cost of a crown or standard complete or partial denture toward the cost of the implant associated appliance, i.e. the implant supported crown or denture.

Limitations on Orthodontic Benefits:

- Payment for orthodontics is provided monthly.
- Orthodontic Benefits begin with the first payment due after the person becomes covered, if treatment has begun.
- Benefits end with the next payment due if the patient loses coverage, treatment is stopped or the Contract is canceled/terminated.
- Benefits are not paid to repair or replace any Orthodontic appliance furnished, in whole or in part, under this program.
- X-rays or extractions are not subject to the Orthodontic maximum.
- Surgical procedures are not subject to the Orthodontic maximum.

Limitations on All Benefits - Optional Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. For example:

- a crown where a filling would restore the tooth;
- a precision denture/partial where a standard denture/partial could be used;
- an inlay/onlay instead of an amalgam restoration; or
- a composite restoration instead of an amalgam restoration on posterior teeth.

If you receive Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. You will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

EXCLUSIONS**Delta Dental does not pay Benefits for:**

- treatment of injuries or illness covered under workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- cosmetic surgery or dentistry for purely cosmetic reasons.
- services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration

of the teeth) and anodontia (congenitally missing teeth), unless the service is provided to a newborn or adopted dependent child for treatment of a medically diagnosed congenital defect.

- treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. For example: equilibration, periodontal splinting, occlusal adjustment.
- any Single Procedure started prior to the date the person became covered for such services under this program.
- prescribed drugs, medication, pain killers or experimental procedures.
- charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
- charges for anesthesia, other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services.
- extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- treatment performed by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.
- charges incurred for oral hygiene instruction, a plaque control program, dietary instruction, x-ray duplications, cancer screening or broken appointments.
- services or supplies covered by any other health plan of the Contractholder.
- services for any disturbances of the temporomandibular (jaw) joints.

COORDINATION OF BENEFITS ("COB")

Delta Dental matches the Benefits under this program with your Benefits under any other group prepaid program or Benefit plan including another Delta Dental plan. (This does not apply to a blanket school accident policy). Benefits under one of the programs may be reduced so that your combined coverage does not exceed the Dentist's fees for the covered services. If this is the "primary" program, Delta Dental will not reduce Benefits, but if the other program is the primary one, Delta Dental will reduce Benefits otherwise payable under this program. The reduction will be the amount paid for or provided under the terms of the primary program for services covered under the Contract (see Benefits and Limitations).

- How does Delta Dental determine which is the "primary" program?
 - (1) If the other Plan is not primarily a dental plan, this Plan is primary.
 - (2) If the other Plan is a dental program, the following rules are applied:
 - a) the Plan covering the patient as an employee is primary over a Plan covering the patient as a dependent.
 - b) the Plan covering the patient as an employee is primary over a Plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - i) secondary to the Plan covering the insured person as a dependent and
 - ii) primary to the Plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the Plan covering the insured person as a dependent are determined before those of the Plan covering that insured person as other than a dependent.
 - (3) Except as stated below, when this Plan and another Plan cover the same child as a dependent of different persons, called parents:
 - a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year, but
 - b) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
 - c) However, if the other Plan does not have the birthday rule described above, but instead has a rule based on 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.

- d) In the case of a dependent child of divorced parents, the Plan covering the patient as a dependent of the parent with legal custody, or as a dependent of the custodial parent's spouse (i.e. step-parent) will be primary over the Plan covering the patient as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.

If the specific terms of a court decree state that the parents will 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 outlined in (3) a) through (3) c).

- (4) The benefits of a Plan which covers an insured person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that insured person as a laid off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- (5) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following will be the order of benefit determination:
- a) First, the benefits of a Plan covering the insured person as an employee, member or subscriber (or as that insured person's dependent);
 - b) Second, the benefits under the continuation coverage.
- If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- (6) If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee longer are determined before those of the Plan which covered that insured person for the shorter term.

AUTOMATED INFORMATION LINE

You may access Delta Dental's automated information line on a regular business day to obtain information on Member Eligibility and Benefits; Group Benefit Information; Claim Status or to speak to a Customer Service Representative for assistance. **AVA (800) 521-2651**

CLAIMS

Claims for Benefits must be filed on a standard Claim Form which you or your Dentist may obtain from:

Delta Dental Insurance Company
P.O. Box #1809
Alpharetta, Georgia 30023
(800) 521-2651
deltadentalins.com

PRE-TREATMENT ESTIMATES

A Dentist may file a Claim Form before treatment, showing the services to be provided to an Enrollee. Delta Dental will predetermine the amount of Benefits payable under the Contract for the listed services. Benefits will be processed according to the terms of the Contract when the treatment is performed. Pre-Treatment Estimates are valid for 60 days, or until an earlier occurrence of any one of the following events:

- the date the Contract terminates;
- the date the patient's coverage ends; or
- the date the PPO Dentist's or Premier Dentist's Agreement with Delta Dental ends.

CLAIMS APPEAL

Delta Dental will notify the Primary Enrollee if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. The Enrollee has 180 days after receiving a notice of denial to appeal it by writing to Delta Dental giving reasons why the denial was wrong. The Enrollee may also ask Delta Dental to examine any additional information he/she includes that may support his/her appeal.

Delta Dental will make a full and fair review within 60 days after Delta Dental receives the request for appeal. Delta Dental may ask for more documents if needed. In no event will the decision take longer than 60 days. The review will take into

account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. The review will be conducted for Delta Dental by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. The identity of such dental consultant is available upon request whether or not the advice was relied upon.

If the Enrollee believes he/she needs further review of said claim, he/she may contact his/her state insurance regulatory agency if applicable or bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if the Contract is subject to ERISA.

GENERAL PROVISIONS

Clinical Examination

Before approving a claim, Delta Dental will be entitled to receive, to such extent as may be lawful, from any attending or examining Dentist, or from hospitals in which a Dentist's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, an Enrollee as may be required to administer the claim, or that an Enrollee be examined by a dental consultant retained by Delta Dental, in or near his community or residence. Delta Dental will in every case hold such information and records confidential.

Notice of Claim Forms

Delta Dental will give any Dentist or Enrollee, on request, a standard Claim Form to make claim for Benefits. To make a claim, the form must be completed and signed by the Dentist who performed the services and by the Enrollee (or the parent or guardian if the patient is a minor) and submitted to Delta Dental.

If the form is not furnished by Delta Dental within 15 days after requested by a Dentist or Enrollee, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to Delta Dental, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Written Notice of Claim/Proof of Loss

Delta Dental must be given written proof of loss within 90 days after the date of the loss. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated).

All written proof of loss must be given to Delta Dental within six (6) months of the termination of the Contract.

Time of Payment

Claims payable under this Contract for any loss other than loss for which this Contract provides any periodic payment will be paid within 30 days after written proof loss is received. Delta Dental will notify the Primary Enrollee and his/her dentist of any additional information needed to process the claim within this 30 day period. Delta Dental will process the claim within 15 days of receipt of the additional information. If the requested information is not received within 45 days, the claim will be denied. Subject to due written proof of loss, all accrued indemnities for loss for which this Contract provides periodic payment will be paid monthly.

To Whom Benefits are Paid

PPO Dentists and Premier Dentists will be paid directly. Any other payments provided by the Contract will be made to the Primary Enrollee, unless the Enrollee requests when filing a proof of loss claim that the payment be made directly to the Dentist providing the services. All Benefits not paid to the Dentist will be payable to the Enrollee, or to his estate, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to the parent, guardian or other person actually supporting him.

Legal Actions

No action at law or in equity will be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract, nor will an action be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by the Contract.

Cancellation of Program

- on an anniversary of the Effective Date upon 60 days written notice; or
- if your employer does not pay the monthly cost of coverage upon 31 days written notice; or
- if your employer does not provide a list of who is eligible upon 60 days written notice; or
- if less than the minimum number of Primary enrollees required under the Contract reported eligible for three (3) months or more, upon 15 days written notice.

THIS BOOKLET CONSTITUTES ONLY A SUMMARY OF THE DENTAL SERVICE CONTRACT. THE COMPLETE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.