



deltadentalins.com

Group No: 16711

Effective Date: January 1, 2014

**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:



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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>Base Plan</i>		<i>High Plan</i>	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic & Preventive Benefits:	100%	100%	100%	100%
Basic Benefits:	80%	80%	80%	80%
Major Benefits:	50%	50%	80%	80%
Orthodontic Benefits:	Not Covered		80%	80%
DEDUCTIBLES:				
Per Enrollee per Calendar Year:	\$50		\$50	
Per Family per Calendar Year:	\$150		\$150	
Diagnostic and Preventive Benefits and Orthodontic Benefits, if applicable, are not subject to the deductible.				
MAXIMUM AMOUNTS:				
Per Enrollee per Calendar Year:	\$1,000		\$1,500	
Diagnostic & Preventive Benefits are not subject to the Calendar Year Maximum Amount.				
If you switch between the plans during a Calendar Year, the Maximum Amounts may be adjusted accordingly.				
Lifetime Orthodontic Services for each Enrollee:	Not Covered		\$1,000	

Lifetime Maximum 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 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.

NOTICE:

Since this information is being provided in electronic format, its accuracy should be verified before receiving treatment. This information is not a guarantee of covered benefits, services or payments.

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 or a Delta Dental Premier[®] Dentist. Out-of-Network Benefits are those covered by the Contract but performed by a 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 PPO 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.

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

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

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 time 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, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child 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
- Spouse's gain or loss of other dental coverage.

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/usg. 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 present, permanent employees working the 30 hours per week 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 their date of hire.

Retired employees are eligible for coverage as defined by the Contractholder's policy.

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

Dependents are your:

- a) Lawful spouse;
- b) Unmarried dependent children from birth to the end of the month of their 26th birthday. Children include natural children, step-children, adopted children and foster children. The child must be dependent on the Primary Enrollee for support. Newborn infants are eligible from the moment of birth. Adopted children are eligible from the moment of placement in the physical custody of the Eligible Person, as certified by the

agency making placement. A child shall automatically be covered for 30 days after birth or adoption placement. To continue coverage after 30 days, notice of the birth or placement and additional fee, if any, must be received within the 30-day period by your institution's Human Resources/Benefits office.

An unmarried child 19 years or older may continue to be eligible as a dependent if the child is not a full-time student, and:

- a) not self-supporting because of mental incapacity or physical handicap that began before age 19, and
- b) the child must be mostly dependent on the Eligible Person for support and maintenance.

Proof of these facts must be given to Delta Dental or Contractholder within 30 days if it is requested. Proof will not be required more than once a year after the child is 21.

Dependents in military service are not eligible.

Enrollment Requirements

Because you are paying all of the cost of coverage for yourself or your dependents then:

- You must enroll within 30 days after the date you become eligible or during an Open Enrollment Period.
- All dependents must be enrolled within 30 days after they become eligible or during an Open Enrollment Period.
- You must pay the cost of coverage in the manner elected by the Contractholder and approved by Delta Dental. Coverage cannot be dropped or changed other than during an Open Enrollment Period or because of a Qualifying Status Change.
- 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, coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change.
- If both you and your spouse are eligible persons, you may be covered under your own Primary Enrollee coverage, or as a dependent under the family coverage of your spouse, but not both. 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 on the last day of the month you stop working for the Contractholder or immediately when this program ends. Your dependents' coverage ends when your coverage ends or on the date when dependent status is lost.

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*, or as permitted by your institution. 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. Because you are paying 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.

Any charges incurred in excess of the Calendar Year Maximum or the lifetime Orthodontic maximum will be the responsibility of the Enrollee.

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 Georgia, 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.

BASE PLAN

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 Major Benefit) for payment purposes), topical application of fluoride solutions and space maintainers.
- Sealants: Applicable to Enrollees ages six (6) to 18, Typically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.

Basic Benefits:

- Simple extractions: extractions of erupted tooth or exposed root.
- General Anesthesia or IV Sedation: when administered by a Dentist for covered oral surgery or selected endodontic and periodontal surgical procedures.
- Palliative: treatment to relieve pain.
- 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).
- Other Basic Services: injectable antibiotics.

Major Benefits:

- Endodontics: treatment of the tooth pulp.
- Periodontics: treatment of gums and bones supporting teeth.
- Oral Surgery: extractions (excluding extractions of impacted teeth) and other surgical procedures including pre-and post-operative care.

Note: Surgical extraction of impacted teeth may be covered under the Contractholder's medical plan.

- 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; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
- Denture Repairs: repair to partial or complete dentures including rebase procedures and relining.
- Other Major Services: occlusal guards, injectable antibiotic, recementation of crown/inlay/onlay, osseous surgery.

LIMITATIONS

Limitations on Diagnostic and Preventive Benefits:

- Delta Dental will pay for routine oral examinations and cleanings (including periodontal cleanings) no more than twice in any Calendar Year while the person is an Enrollee under any Delta Dental program or dental care program provided by the Contractholder. Note that periodontal cleanings are covered as a Major Benefit and routine cleanings are covered as a Diagnostic and Preventive Benefit.
- Full-mouth x-rays and panoramic x-rays are limited to once every five (5) years while the person is an Enrollee under any Delta Dental program.
- Bitewing x-rays are provided once each 12 months for you and your spouse and once in a 6 month period for your Dependent Child Enrollees.
- Topical application of fluoride solutions is limited to once in any 12 month period for Enrollees under age 19.
- Space maintainers are limited to the initial appliance only and to Enrollees under age 16.
- Sealants are limited as follows:
 - (1) to permanent teeth for Enrollees age six (6) to age 18 if they are without cavities or restorations on the occlusal surface.
 - (2) do not include repair or replacement of a sealant on any tooth within three (3) years of its application.

Limitations on Basic Benefits:

- Delta Dental will not pay to replace an amalgam, synthetic porcelain or plastic restorations (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.

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 and/or implants 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 and/or implant supported prosthesis not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. Delta Dental will pay for the removal of an implant once for each tooth during the Enrollee's lifetime.
- Delta Dental limits payment for dentures to a standard partial or complete 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.

HIGH PLAN

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.
- Sealants: Applicable to Enrollees ages six (6) to 18, topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.

Basic Benefits:

- General Anesthesia or IV Sedation: when administered by a Dentist for covered oral surgery or selected endodontic and periodontal surgical procedures.
- Endodontics: treatment of the tooth pulp.
- Periodontics: treatment of gums and bones supporting teeth.
- Palliative: treatment to relieve pain.
- 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).
- Other Basic Services: occlusal guards, injectable antibiotics.

Major Benefits:

- Oral Surgery: extractions (excluding extractions of impacted teeth) and other surgical procedures including pre-and post-operative care.

Note: surgical extraction of impacted teeth may be covered under the Contractholder's medical plan.
- 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; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
- Denture Repairs: repair to partial or complete dentures including rebase procedures and relining.
- Other Major Services: occlusal guards, injectable antibiotic, recementation of crown/inlay/onlay, osseous surgery.

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.

LIMITATIONS**Limitations on Diagnostic and Preventive Benefits:**

- Delta Dental will pay for routine oral examinations and cleanings (including periodontal cleanings) no more than twice in any Calendar Year while the person is an Enrollee under any Delta Dental program 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.
- Full-mouth x-rays and panoramic x-rays are limited to once every five (5) years while the person is an Enrollee under any Delta Dental program.
- Bitewing x-rays are provided once each 12 months for you and your spouse and once in a 6 month period for your Dependent Child Enrollees.
- Topical application of fluoride solutions is limited to once in any 12 month period for Enrollees under age 19.
- Space maintainers are limited to the initial appliance only and to Enrollees under age 16.
- Sealants are limited as follows:
 - (1) to permanent teeth for Enrollees age six (6) to age 18 if they are without cavities or restorations on the occlusal surface.
 - (2) do not include repair or replacement of a sealant on any tooth within 36 months of its application.

Limitations on Basic Benefits:

- Delta Dental will not pay to replace an amalgam, synthetic porcelain or plastic restorations (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.

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 and/or implants 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 and/or implant supported prosthesis not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. Delta Dental will pay for the removal of an implant once for each tooth during the Enrollee's lifetime.
- Delta Dental limits payment for dentures to a standard partial or complete 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.

Limitations on Orthodontic Benefits:

- The maximum amount payable for each Enrollee during the Enrollee's lifetime is shown on the Group Highlights page.
- Orthodontic Benefits will be paid on a prorated basis over the length of the course of treatment.
- Benefits are not paid to repair or replace any orthodontic appliance received under this program.
- Benefits are not provided for orthodontic retreatment procedures.
- Non-orthodontic procedures performed for the purpose of orthodontic treatment are subject to the Orthodontic coinsurance and lifetime maximum if covered as Benefits under Delta Dental's standard processing policies.

ALL PLANS

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 general anesthesia and IV sedation administered by a licensed Dentist in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.
- 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.
- Appliance for correction of harmful habits.
- services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Benefits section, if applicable.
- services for any disturbances of the temporomandibular (jaw) joints.
- any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.

COORDINATION OF BENEFITS

A number of dental plan members and enrolled dependents may be covered under another dental plan that provides dental benefits on a group-insurance basis. If you are such a member, you should be informed about the indemnity plan's provision for "Coordination of Benefits (COB)".

The indemnity plan's COB provision stipulates that, when there is multiple coverage by two or more group-insurance dental benefit plans, reimbursement by the Board of Regents indemnity plan will not exceed 100% of the covered charges incurred. Covered charges do not include member penalties assessed for plan non-compliance.

The COB provision applies to any group-insurance dental benefit plan. Examples would include governmental programs, such as Medicare; or the employer of a spouse who offers group-insurance dental benefits. COB does not apply to an individual policy for dental coverage for which the member pays the total premium directly to the insurer. To administer the COB provision, it must be determined which group-insurance dental plan is deemed to have "primary" coverage. The primary plan will be required to initially process and pay any covered dental claims. This generally means that the primary plan will pay for the majority of the costs associated with such claims. Any other group-insurance dental plan(s) is deemed to have "secondary" coverage responsibilities.

The decision regarding which group-insurance dental plan is “primary”, is made as follows:

- 1) A plan without a Coordination of Benefits (COB) provision is primary over a plan with COB provision.
- 2) A group-insurance dental plan that covers an individual as an active or retired employee is primary over a group-insurance dental plan that covers an individual as a dependent.
- 3) For children, the dental plan of the parent whose birthday occurs earlier in the calendar year is deemed to be primary. If both parents’ birthdays occur on the same day, the dental plan that has insured the parent for the longest period of time is primary. If one of the plans does not have the parent birthday rule, the father’s dental plan is primary.
- 4) For children of separated or divorced parents:
 - a) When a court decree has determined that one parent has financial responsibility for medical, dental or other healthcare expenses of a child, the dental plan of the parent with court-decreed financial responsibility is primary to any other plan covering the child (regardless of which parent has custody).
 - b) When a court decree states that the parents will share joint custody, without specifying which parent has financial responsibilities for medical or dental care expenses of a child, the plan providing primary coverage for the child, will follow the sequence of benefit determination rules presented below:
 - i. The dental plan of the parent whose birthday occurs earlier in the calendar year is primary;
 - ii. When both parents’ birthdays occurs on the same day, the dental plan that has insured the parent for the longest period of time is primary; and
 - iii. If one of the plans does not have the parent birthday rule, the father’s dental plan is primary.
 - c) In the absence of court-decreed financial responsibility:
 - i. For dental plans that cover a child of separated or divorced parents who have not remarried, the dental plan of the parent with custody is deemed to be primary.
 - ii. For dental plans that cover a child of remarried parent(s):
 - (1) The dental plan of the remarried parent, with custody, is deemed to be primary;
 - (2) The dental plan of the step-parent is deemed to be secondary; and
 - (3) The dental plan of the biological parent, without custody, is deemed to have the third level of dental care payment responsibility.
- 5) The dental plan that covers an insured individual as an active employee is primary over a dental plan that covers a retiree, or, a laid-off employee. The same process is true for an active employee covered by his/her employer’s group-insurance dental plan who is also covered as a dependent under a retiree’s/laid-off employee’s group-insurance dental plan. An active employee’s dental plan will have primary coverage responsibilities. Benefits under the Board of Regents indemnity dental plan will be coordinated with dental benefits provided by the federal Medicare program, if appropriate.

If you return to active employment with another employer after you reach age 65 and you are covered by the new employer’s group-insurance dental plan, then: (1) your new employer’s dental plan will be primary; and (2) the Board of Regents dental plan will serve as secondary.

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) 471-4214**

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) 471-4214
deltadentalins.com/usg

PRE-TREATMENT ESTIMATES

A Dentist may file a Claim Form before treatment for services \$350 and over 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.

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 12 months 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).

Proof of loss means written evidence satisfactory to Delta Dental that a person has satisfied the conditions and requirements for any benefit described under this plan. When a claim is made for any benefit, proof must be established. The following information must be included on the claim form:

- Name of the Contractholder and group number, exactly as it appears on your member identification card;
- Provider documentation of medical treatment/services and detailed diagnosis;
- A copy of the provider's billing statement indicating the name of the patient;
- The type of treatment or services rendered;
- The date and charges for treatment or services; and
- The signature of the provider.

All written proof of loss must be given to Delta Dental within 12 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 the minor Enrollee.

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.