DELTA DENTAL®

Certificate of Coverage

University of Illinois
Graduate Assistants and Graduate Students

Group Number 5436

Delta Dental PPO

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SECTION I: INTRODUCTION

About This Booklet

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

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

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

The definitions for the words that appear in *italics* 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. A touch-tone phone is required. You can check claim status and obtain *dentist* referral information on the Web site or by using the automated phone system. Your questions may be answered most quickly by use of the Web site or automated phone system.

You also may contact us at 1-800-323-1743 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.

SECTION 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.

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, Delta Dental will issue payment to you, and 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* At the *dentist's* discretion, you may have to pay the entire bill in advance.

If I go to a *dentist* who does not participate in the Delta Dental PPO or Delta Dental Premier networks, may I assign my benefits to the *dentist*?

No. Your group dental plan does not permit assignment of benefits.

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. At the end of this section – Section II – we have included an annotated Explanation of Benefits Statement to indicate what information is included on this form. 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 *dentist*s 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 1-800-323-1743.

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 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.

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 (in-network *dentist*): 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.

If you are paid directly (out-of-network *dentist*): 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 in whole or in part by written request within 180 days from the date of the denial notice. Send your written request for review to:

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

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

See Appendix E for the provisions governing claim denials and appeal procedures under your group dental plan.

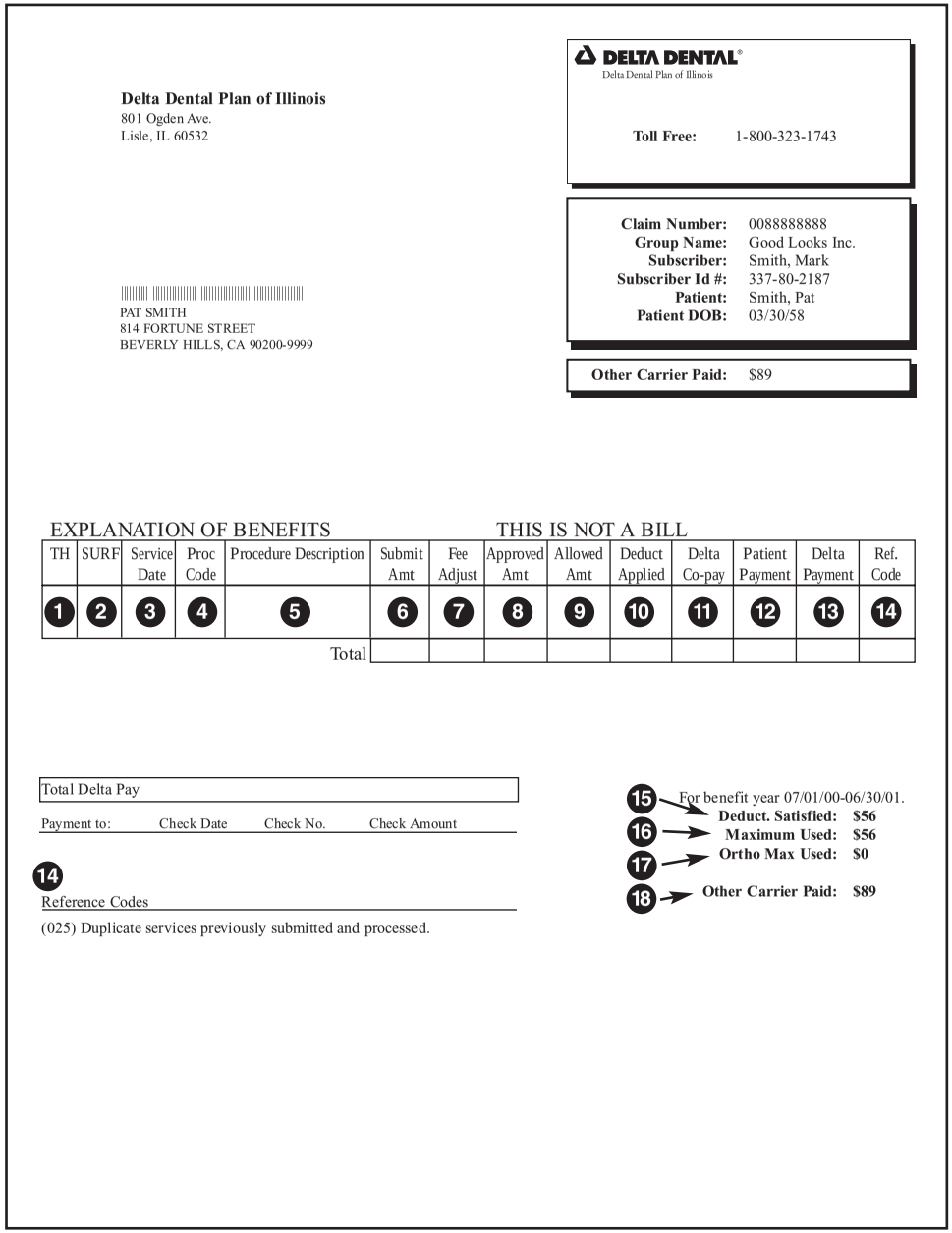
DELTA DENTAL®
Delta Dental Plan of Illinois

C-EOB

Delta Dental Plan of Illinois' Explanation of Benefits Form

Use this reference to understand how Delta Dental Plan of Illinois calculates payment of claims.

1 TH	The tooth or area of the mouth that was treated.
2 SURF	The tooth surface that was treated.
3 Service Date	The date the procedure was completed.
4 Proc. Code	The alpha-numeric code that identifies the procedure that was requested or completed.
5 Proc. Description	A description of the procedure that was requested or completed.
6 Submit Amt	The charges billed by the dentist.
7 Fee Adjust	The difference, if any, between the Submitted Amount and the Approved Amount.
8 Approved Amt	The amount the dentist has agreed to accept as full payment for covered services. For network dentists, the Approved Amount is the lesser of the Submitted Amount or the applicable maximum plan allowance/negotiated amount. For non-network dentists, the Approved Amount is the same as the Submitted Amount.
9 Allowed Amt	The amount that Delta Dental uses to calculate its payment responsibility under the terms of the patient's group dental plan.
10 Deduct. Applied	The deductible is the amount the patient must pay before his/her group dental plan's benefits begin. If the procedure is subject to a deductible, this column will indicate the amount that has been subtracted from the Allowed Amount before calculating Delta Dental's payment and the Patient's Payment.
11 Delta Co-Pay	The portion of the Allowed Amount Delta Dental will pay, up to the patient's group dental plan's maximum.
12 Patient Payment	The amount the patient is responsible for paying under the terms of his/her Delta Dental group dental plan. If the procedure is subject to a deductible, the Patient Payment includes the amount from the Deductible Applied column. Except in certain circumstances involving coordination of benefits with another plan, a Delta Dental network dentist may only bill the patient for this amount.
13 Delta Payment	The amount Delta Dental paid.
14 Ref. Code	The reason benefits for the procedure have been limited or denied under the terms of the patient's group dental plan.
15 Deduct. Satisfied	The amount the patient has paid to date toward his/her annual deductible.
16 Maximum Used	The amount of the patient's annual maximum coverage limit used to date.
17 Ortho Max Used	The amount of the lifetime maximum coverage limit for orthodontic benefits used to date.
18 Other Carrier Paid	The amount paid under the provisions of another group dental plan when benefits have been coordinated and this plan is not primary.



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

DELTA DENTAL®
Delta Dental Plan of Illinois

Toll Free: 1-800-323-1743

Claim Number: 0088888888
Group Name: Good Looks Inc.
Subscriber: Smith, Mark
Subscriber Id #: 337-80-2187
Patient: Smith, Pat
Patient DOB: 03/30/58

PAT SMITH
814 FORTUNE STREET
BEVERLY HILLS, CA 90200-9999

Other Carrier Paid: $89

EXPLANATION OF BENEFITS THIS IS NOT A BILL

TH	SURF	Service Date	Proc Code	Procedure Description	Submit Amt	Fee Adjust	Approved Amt	Allowed Amt	Deduct Applied	Delta Co-pay	Patient Payment	Delta Payment	Ref. Code
1	2	3	4	5	6	7	8	9	10	11	12	13	14
				Total									

Total Delta Pay

Payment to: Check Date Check No. Check Amount

14
Reference Codes
(025) Duplicate services previously submitted and processed.

15 For benefit year 07/01/00-06/30/01.
16 **Deduct. Satisfied: $56**
17 **Maximum Used: $56**
18 **Ortho Max Used: $0**
Other Carrier Paid: $89

SECTION III: YOUR COVERED SERVICES AND DENTAL BENEFITS

What services are covered under this group dental plan?

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

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.

SECTION IV: ENROLLMENT AND CHANGES TO ENROLLMENT

Who is eligible to enroll in this group dental plan?

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

If you are eligible for coverage under this group dental plan, your adopted child is eligible from 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?

Yes, verification of eligible full-time student status will be required with the first claim submitted for each school year.

Is the limiting age extended for disabled *dependents*?

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

When may I elect coverage?

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

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

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

What is a qualifying status change?

Qualifying status changes include the following:

- Changes in family status, to include ONLY: change in your legal marital status; change in the number of *dependents*; or a *dependent's* satisfying (or no longer satisfying) *dependent* eligibility requirements.
- Taking or returning from a leave of absence under the Family and Medical Leave Act of 1993 (FMLA) or a military leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

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

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

When does coverage terminate?

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.

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

SECTION 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 *deductible*s, 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 and conditions of this group dental plan. The *group subscriber* shall be responsible for distributing copies of the *certificate of coverage* to *subscribers*.

"Co-Payment" 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 in this Certificate of Coverage.

"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 and conditions contained in this Certificate of Coverage.

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

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

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

“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.

“Pretreatment Estimate” means an estimate of the coverage afforded under this group dental plan for *dental benefits* prior to such services being rendered.

“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.

SCHEDULE OF DENTAL BENEFITS

Non-listed procedures are not covered under this group dental plan.

	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 calendar year*	100%	100%	90%	N	N	N
Intra-oral – periapical radiographs	100%	100%	90%	N	N	N
Bitewing x-rays (not including vertical bitewings): *twice per calendar 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, one set of vertical bitewings, 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

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

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

PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): *twice per calendar year*	100%	100%	90%	N	N	N
Topical fluoride applications: *once per calendar year, for dependent children under age 19*	100%	100%	90%	N	N	N

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, *only when provided in a dentist's office*	80%	80%	70%	N	N	N
RESTORATIVE SERVICES						
Amalgam and anterior resin-based composite fillings *once per surface in a 12-month interval*. *When a resin filling is placed on a molar or pre-molar (except on the facial surface of a pre-molar), the level of benefits will be limited to that of an amalgam filling.*	80%	80%	70%	N	N	N
Inlays and onlays (permanent teeth only)	50% of TOA*	50% of TOA*	50% of TOA*	Y	Y	Y
Crowns and ceramic restorations (permanent teeth only)	50% of TOA*	50% of TOA*	50% of TOA*	Y	Y	Y
Recementation of inlays, onlays, partial coverage restorations, cast or prefabricated posts and cores and crowns	50% of TOA*	50% of TOA*	50% of TOA*	Y	Y	Y
Prefabricated stainless steel crowns	50% of TOA*	50% of TOA*	50% of TOA*	Y	Y	Y
Pin retention	50% of TOA*	50% of TOA*	50% of TOA*	Y	Y	Y
Cast or prefabricated post and core; core build-up	50% of TOA*	50% of TOA*	50% of TOA*	Y	Y	Y
Crown repair	50% of TOA*	50% of TOA*	50% of TOA*	Y	Y	Y

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

ENDODONTIC SERVICES						
Root canal therapy	50% of TOA*	50% of TOA*	50% of TOA*	Y	Y	Y

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.

*See the Table of Allowances (TOA) on page A-3. This group dental plan will pay 50% of the dollar amount shown on the TOA for the listed procedures, subject to all limitations and exclusions of the plan. You will be responsible for the balance of the:

- Fee Schedule or Scheduled Fee, as defined on page 12 of the Certificate, for treatment received from a Delta Dental PPO dentist.
- Maximum Plan Allowance, as defined on page 13 of the Certificate, for treatment received from a Delta Dental Premier dentist.
- dentist's submitted fee, for treatment received from a non-Delta dentist.

TABLE OF ALLOWANCES - MAJOR RESTORATIVE AND ENDODONTIC SERVICES

PROCEDURE		ALLOWANCE
INLAY/ONLAY RESTORATIONS		
2510	Inlay - metallic - one surface	$328.00
2520	Inlay - metallic - two surfaces	$365.33
2530	Inlay - metallic - three or more surfaces	$420.00
2542	Onlay - metallic - two surfaces	$461.00
2543	Onlay - metallic - three surfaces	$499.00
2544	Onlay - metallic - four or more surfaces	$524.00
2610	Inlay - porcelain/ceramic - one surface	$338.00
2620	Inlay - porcelain/ceramic - two surfaces	$370.00
2630	Inlay - porcelain/ceramic - three or more surfaces	$400.00
2642	Onlay - porcelain/ceramic - two surfaces	$452.00
2643	Onlay - porcelain/ceramic - three surfaces	$476.00
2644	Onlay - porcelain/ceramic - four or more surfaces	$512.00
2650	Inlay - resin-based composite - one surface	$304.00
2651	Inlay - resin-based composite - two surfaces	$359.00
2652	Inlay - resin-based composite - three or more surfaces	$410.00
2662	Onlay - resin-based composite - two surfaces	$436.00
2663	Onlay - resin-based composite - three surfaces	$463.00
2664	Onlay - resin-based composite - four or more surfaces	$499.00
CROWNS - SINGLE RESTORATIONS ONLY		
2710	Crown - resin (indirect)	$352.00
2712	Crown-3/4 resin-based composite (indirect)	$352.00
2720	Crown - resin with high noble metal	$468.00
2721	Crown - resin with predominantly base metal	$384.00
2722	Crown - resin with noble metal	$449.00
2740	Crown - porcelain/ceramic substrate	$556.00
2750	Crown - porcelain fused to high noble metal	$567.00
2751	Crown - porcelain fused to predominantly base metal	$508.00
2752	Crown - porcelain fused to noble metal	$560.00
2780	Crown - 3/4 cast high noble metal	$556.00
2781	Crown - 3/4 cast predominantly base metal	$551.00
2782	Crown - 3/4 cast noble metal	$544.00
2783	Crown - 3/4 porcelain/ceramic	$556.00
2790	Crown - full cast high noble metal	$566.00
2791	Crown - full cast predominantly base metal	$496.00
2792	Crown - full cast noble metal	$543.00
2794	Crown – titanium	$551.00

PROCEDURE		ALLOWANCE
OTHER RESTORATIVE SERVICES		
2910	Recement inlay	$41.00
2915	Recement cast or prefabricated post and core	$41.00
2920	Recement crown	$42.00
2930	Prefabricated stainless steel crown - primary tooth	$153.00
2931	Prefabricated stainless steel crown - permanent	$157.00
2950	Core build-up, including any pins	$122.00
2951	Pin retention - per tooth, in addition to restoration	$31.00
2952	Cast post and core in addition to crown	$192.00
2954	Prefabricated post and core in addition to crown	$156.00
2980	Crown repair, by report	$133.00
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)		
3310	Anterior (excluding final restoration)	$407.00
3320	Bicuspid (excluding final restoration)	$519.00
3330	Molar (excluding final restoration)	$535.00
ENDODONTIC RETREATMENT		
3346	Retreatment of previous root canal therapy – anterior	$465.00
3347	Retreatment of previous root canal therapy – bicuspid	$634.00
3348	Retreatment of previous root canal therapy – molar	$609.00

APPENDIX B
EXCLUSIONS

GENERAL EXCLUSIONS THAT APPLY TO ALL PROCEDURES:

Coverage is NOT provided for:

- Services compensable under Worker's Compensation or Employer's Liability laws.

- Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges which the person is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its Amendments.

- Services performed to correct developmental malformation including, but not limited to, cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis and congenitally missing teeth. This exclusion does not apply to *newborn infants.*

- Services performed for purely cosmetic purposes, including, but not limited to, tooth-colored veneers, bonding, porcelain restorations and microabrasion. Orthodontic care benefits shall fall within this exclusion unless such benefits are provided by endorsement.

- Charges for services completed prior to the date the person became covered under this program.

- Services for anesthetists or anesthesiologists.

- Temporary procedures.

- Any procedure requested or performed on a tooth when radiographs indicate that less than 40% of the root is supported by bone.

- Services performed on non-functional teeth (second or third molar without an opposing tooth).

- Services performed on deciduous (primary) teeth near exfoliation.

- Drugs or the administration of drugs.

- Procedures deemed experimental or investigational by the American Dental Association, for which there is no procedure code, or which are inconsistent with Current Dental Terminology coding and nomenclature.

- Services with respect to any disturbance of the temporomandibular joint (jaw joint).

- Procedures, techniques or materials related to implantology or edentulous (toothless) ridge enhancement.

- Procedures that Delta Dental considers to be included in the fees for other procedures. For such procedures, a separate payment will not be made by this group dental plan. A Dentist in the DeltaPreferred Option or DeltaPremier 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.

EXCLUSIONS THAT APPLY TO RESTORATIVE SERVICES:

- Fillings are not a covered benefit when crowns are allowed for the same teeth.

- Replacement of any existing cast restoration (crowns, onlays, ceramic restorations) with any type of cast restoration within 60 months following initial placement of existing restoration is not a covered benefit.

- Replacement of a stainless steel crown with any type of cast restoration is not a covered benefit by the same office within 24 months following initial placement.

- A cast restoration is a covered benefit only in the presence of radiographic evidence of decay or missing tooth structure. Restorations placed for any other purpose, including, but not limited to, cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformations of teeth, or the anticipation of future fractures, are not a covered benefit.

- When there is radiographic evidence of sufficient vertical height (more than three millimeters above the crestal bone) on a tooth to support a cast restoration, a crown build-up is not a covered benefit.

- 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.

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.

APPENDIX C
DENTAL PLAN SPECIFICATIONS

CONTRACT NUMBER: 5436

CERTIFICATE OF COVERAGE ISSUANCE DATE: September 1, 2006

BENEFIT YEAR: September 1st through August 31st.

ELIGIBILITY REQUIREMENTS:

All present graduate assistants, fellows and graduate students of the Group Subscriber are eligible for coverage under this Group Dental Plan.

The effective date of coverage is September 1st or the first day of appointment, whichever is later, for all graduate assistants and fellows who are enrolled in this Group Dental Plan automatically (i.e., those individuals whose premiums are paid by the university).

The effective date of coverage is the date the university enrollment form is completed and payment is received, but in no instance earlier than September 1st for fall and February 1st for spring, for all individuals who enroll in this Group Dental Plan voluntarily within three (3) weeks following the commencement of a Contract Term.

DEPENDENT CHILDREN:

"Dependent children" means those unmarried children who are under the age of 19 or, if full-time students, under the age of 25.

ENROLLMENT REQUIREMENTS:

Except in the event of a qualifying status change:

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

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

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

NON-DUPLICATION OF BENEFITS:

Where an individual has dual coverage and this Group Dental Plan is determined to be secondary, the maximum benefit from this Group Dental Plan shall be an amount that will bring the total benefit payment from both plans up to the maximum benefit that would be payable under this plan if it were primary.

DEDUCTIBLE:

Major Restoration and Endodontic procedures listed in the Schedule of Dental Benefits are subject to a $50 Deductible per Covered Individual per Benefit Period, not to exceed $150 per family unit per Benefit Period.

COVERAGE LIMITS:

The maximum coverage limit per Covered Individual per Benefit Period is $1,000.

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

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

- Through the use of a reference code (numerical code), a statement of the specific reason(s) why the claim was denied, in whole or in part, including 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 in whole or in part on a determination related to dental necessity, experimental treatment or a clinical judgment in applying the terms of your group 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.

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

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

Note that, if you do not use the internal appeal procedures available to you, 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 appeal procedures.

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

APPENDIX F
CONTINUATION OF COVERAGE

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

Part A

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

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

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

What Is COBRA Continuation Coverage?

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

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

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

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

What Qualifying Events Might Trigger COBRA Coverage?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Child Ceasing To Qualify for Coverage. You must notify the Plan Administrator in writing if one or more of your children stops being eligible under this group dental plan as a Dependent child. For example, if your non-disabled child loses status as a full-time student after having attained the limiting age for Dependent coverage, your child no longer qualifies for coverage under this group dental plan as a Dependent child. You must include with your written notice your name, address, contact telephone number, the name of your child, and an explanation of how your child ceased to be an eligible Dependent. You must provide the written notice within 60 days of the date on which your child ceases to qualify for coverage under this group dental plan or the date on which your child loses (or would lose) coverage under this group dental plan, whichever is later.

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

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

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

When Does COBRA Coverage Start?

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

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

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

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

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

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

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

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

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

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

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

When May COBRA Coverage Be Cut Off Early?

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

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

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

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

How Much Does Continuation Coverage Cost?

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

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

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

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

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

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

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

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

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

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

To Whom Should You Direct Questions?

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

Keep the Plan Administrator Informed of Address Changes

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

Part B

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

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

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

Leave Under the Family and Medical Leave Act

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

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

What Happens If Payments Are Not Made During FMLA Leave?

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

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

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

Will Your Coverage Be Reinstated Upon Return from FMLA Leave?

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

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

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

your failure to return to work at the end of FMLA leave. COBRA coverage elected in these circumstances will begin on the last day of FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours.

Part C

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

Military Leave Under the Uniformed Services Employment and Reemployment Rights Act

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

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

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

What Group Health Plan Coverage Will Be Provided?

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

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

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

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

How Long Does USERRA Coverage Last?

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

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

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

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

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

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

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

Part D

Continuation Coverage Rights Under Illinois Law (for covered spouses)

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

What Is Illinois Continuation Coverage?

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

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

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

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

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

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

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

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

When Does Illinois Continuation Coverage Start?

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

How Long Does Illinois Continuation Coverage Normally Last?

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

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

When May Illinois Continuation Coverage Be Cut Off Early?

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

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

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

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

- The date on which the former spouse remarries;

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

How Does Your Spouse Elect Continuation Coverage?

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

How Much Does Illinois Continuation Coverage Cost?

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

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

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

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

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

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

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

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

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

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

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

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

To Whom Do I Direct My Questions?

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

Keep the Plan Informed of Address Changes

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

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

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

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