



Delta Dental of Illinois



Delta Dental PPOSM

Dental Benefits Booklet



PARK DISTRICT RISK MANAGEMENT AGENCY

Group #2001

Effective Date: 01/01/20

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

PARK DISTRICT RISK MANAGEMENT AGENCY ("PDRMA")

IMPORTANT: THIS BOOKLET IS NOT A SUMMARY PLAN DESCRIPTION (SPD). IT DOES NOT FULFILL THE REQUIREMENTS OF AN SPD AS REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA). IT IS INTENDED TO PROVIDE A BRIEF DESCRIPTION OF YOUR DENTAL PLAN BASED ON YOUR PLAN DOCUMENTS. IF THERE IS ANY CONFLICT BETWEEN THIS BOOKLET AND THE COMPLETE TEXT OF THE PLAN DOCUMENT, THEN THE PLAN DOCUMENTS GOVERN AND SHALL SUPERSEDE THIS BOOKLET. YOU MAY REVIEW THE COMPLETE PLAN DOCUMENT AT THE COMPANY'S OFFICES DURING REGULAR BUSINESS HOURS AND MAY OBTAIN COPIES OF ALL OR ANY PART OF THE PLAN DOCUMENT.

Dental Benefits Administered by

DELTA DENTAL OF ILLINOIS
111 Shuman Boulevard
Naperville, Illinois 60563

TABLE OF CONTENTS

Definitions..... 3

General Information on How the Plan Works..... 5

How to File a Claim 5

Eligibility 7

Termination of Coverage..... 10

Dental Benefits 11

Level of Dental Benefits 11

Required Documentation 11

General Provisions

 Notice and Proof of Dental Claims 11

 Coordination of Benefits 12

 Disputed Claims Procedure 14

 Continuation of Benefits 17

Summary of Dental Plan Benefits 22

Schedule of Dental Benefits.....A-1

ExclusionsB-1

Dental Plan Specifications C-1

DEFINITIONS

This Group Dental Plan is subject to the following definitions:

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

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

“Child” means the Participant’s:

- Natural born child or legally adopted child. An adopted child shall be considered a “child” from the moment the child is placed in the custody of the parents for adoption; or
- Stepchild or the Civil Union Partner’s natural born or legally adopted child; or
- child for whom the Participant, the Participant’s Civil Union Partner, or the Employee’s Domestic Partner has been granted legal guardianship by a court of law or agency with appropriate jurisdiction; or
- Child for whom the Participant is required to provide health care coverage under a Qualified Medical Child Support Order. Participants have the right to obtain applicable determination procedures free of charge from the Plan Administrator; or
- Covered Domestic Partner’s child who lives with the Domestic Partner and is a biological or adopted child of a Domestic Partner.

If both parents of a child are covered for benefits, either but not both may cover the child as a Dependent.

“Civil Union Partner” means the Participant’s Civil Union Partner whose union to the Employee has not been legally terminated. Civil unions or similar unions obtained outside the state of Illinois will be recognized.

“Claims Administrator” means Delta Dental of Illinois.

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

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

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

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

“Dental Benefits Booklet” means this booklet issued to a Participant setting forth the terms and conditions of this Group Dental Plan. Member Agencies shall be responsible for distributing this booklet to Participants.

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

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

“Dependent” means Participant’s spouse, Civil Union Partner, or Domestic Partner; Child from birth to the date the child attains age 26. Proof may be required. *(See the section entitled Eligibility for more information.)*

“Dependent Benefits” means the coverage provided under this Plan with respect to a Dependent of a Participant eligible for Dependent Benefits.

“Domestic Partner” means a Participant’s domestic partner who, subject to the Member Agency’s personnel policies and the Member Agency’s election to extend benefits, is eligible for coverage in the PDRMA Health Program. Domestic partners are persons who, at the time of enrollment in the PDRMA Health Program, meet the following qualifications:

- Are at least eighteen (18) years of age or older;
- Are each competent to enter into a contract;
- Are not legally married to any person and are not related by blood to each other to a degree that would prohibit legal marriage;
- Are each other’s sole domestic partner;
- Intend to remain together indefinitely;
- Share a permanent residence;
- Agree to file a Termination of Domestic Partner Relationship form within thirty (30) days if any of the above facts or other conditions to qualify for coverage change;
- Executive an Affidavit, indicating compliance of the persons executing such Affidavit with all the requirements for a Domestic Partner Relationship set forth in the Agency’s policy;
- For a minimum of twelve (12) months, at least three (3) of the following have existed for this Domestic Partner Relationship, and now exist:
 - o Municipal or other form of domestic partnership relationship agreement, certification or registration.
 - o Joint liability under mortgage or lease.
 - o Designation of the Domestic Partner as beneficiary for the Participant’s life insurance, IMRF or other retirement benefits, or an individual retirement account.
 - o Designation of the Domestic Partner as primary beneficiary under Participant’s will.
 - o Holder of durable health care and/or property powers of attorney.
 - o Joint ownership of motor vehicle.
 - o Joint checking, bank or credit account, or investment.
 - o Payment of shared household expenses.
 - o Other substantial documentation of the Domestic Partner Relationship.

An Affidavit by which both the Participant and Domestic Partner confirm their Domestic Partner Relationship will be required for coverage under the PDRMA Health Program, together with documentation confirming the existence of the above items used to qualify. Documentation should clearly indicate the relationship has been in existence for a minimum of one year (e.g. joint bank statement from a year ago and one from current month).

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

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

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

“Member Agency” means each individual agency as a member of PDRMA.

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

- Delta Dental Premier Dentists are bound to accept the Approved Fee as full reimbursement for their services after application of any Deductible and this Group Dental Plan’s benefit payment.
- Non-Delta Dentists have not agreed to accept the Approved Fee as full payment of their services. Non-Delta Dentists may bill the patient the difference between their fee and this Group Dental Plan’s benefit payment.

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

“Personal Benefits” means coverage provided under this Plan with respect to an eligible Participant.

“Plan” means the benefits and provisions, as detailed in this Dental Benefits Booklet, through PDRMA (an intergovernmental cooperative of Park Districts and Special Recreation Associations which was formed to provide group health benefits for employees of Member Agencies).

“Plan Administrator” means the staff administering the PDRMA Plan.

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

“Spouse” means the Participant’s spouse who is not legally divorced from the Participant.

GENERAL INFORMATION ON HOW THE PLAN WORKS

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

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

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

HOW TO FILE A CLAIM

TO USE YOUR GROUP DENTAL PLAN, FOLLOW THESE STEPS

- (1) Please read this Dental Benefits Booklet carefully in order to familiarize yourself with the benefits and provisions of this Group Dental Plan.
- (2) If your Dentist does not have a claim form, you may obtain one from your Benefit Coordinator. Please be sure that the information portion of the claim form includes the following:
 - (a) the Participant’s full name and address;
 - (b) the Participant’s ID number as determined by your employer;
 - (c) the name and date of birth of the person receiving dental treatment; and
 - (d) the group name and number.
- (3) If your Dentist is not familiar with this Group Dental Plan or has any questions regarding this Group Dental Plan, he/she may contact Delta Dental of Illinois, 111 Shuman Boulevard, Naperville, Illinois 60563; telephone (800) 323-1743.
- (4) If your Dentist expects that the total fees for your dental treatment will exceed \$200, then DDIL recommends that a request for the predetermination of plan benefits be submitted, prior to treatment, to the Dental Plan Director, Delta Dental of Illinois, P.O. Box 5402, Lisle, Illinois 60532, so that you and your Dentist are aware of the coverage afforded under this Group Dental Plan prior to services being rendered. This request must show your dental needs and a

description of the procedures and services which the treating dentist plans to perform, including the actual fees to be charged for each procedure or service.

- (5) DDIL will review the request for predetermination of plan benefits and the required documentation (as set forth in the section titled Required Documentation) submitted by the treating Dentist in order to determine the level of payment under this Group Dental Plan. A pre-treatment determination does not take into account other coverage you may have; DDIL coordinates its benefits with another group dental plan after treatment has been completed.
- (6) After your treating Dentist has completed the dental services outlined in the Predetermined Benefit Voucher, this voucher is to be resubmitted to DDIL, indicating the date each dental procedure or service was rendered. If procedures or services are rendered after 90 days from the date this Group Dental Plan issued its payment determination, as outlined in the Predetermined Benefit Voucher, the claim must be submitted to DDIL with the required documentation set forth in the section titled Required Documentation. This Proof of Claim should be furnished within 90 days after you have received the Dental Benefit.
- (7) If a request for predetermination of plan benefits is not submitted in advance as requested, this Group Dental Plan reserves the right to make a determination of the level of payment, taking into account the provisions of this Group Dental Plan. A determination made by DDIL imposes no restrictions on the method of diagnosis or treatment by a treating Dentist and only relates to the level of payment which this Group Dental Plan is required to make.
- (8) Submission of a request for predetermination of plan benefits before treatment commences is not requested for:
 - (a) procedures and services where the total fees are less than \$200;
 - (b) emergency examination and treatment for accidental injuries; emergency treatment for relief of pain when not related to a final procedure; and
 - (c) oral surgery necessitated as a result of an injury.

TREATMENT PLANS AND CLAIMS TO BE SENT TO:

Delta Dental of Illinois
P.O. Box 5402
Lisle, Illinois 60532

FOR CLAIM INQUIRIES, CONTACT DELTA DENTAL OF ILLINOIS AT:

TELEPHONE: (1-800) 323-1743
E-MAIL: CSI@deltadentalil.com

ELIGIBILITY

A. PARTICIPANT ELIGIBILITY

An eligible Participant is:

· **EMPLOYEE**

Employee eligibility for coverage under the Plan depends in part upon the personnel policies of the Member Agency for whom the Employee works. Generally speaking, a Member Agency may choose to apply one of the following three eligibility criteria to its Employees:

(i) A Member Agency's Employee will be eligible if the Employee is directly employed by a Member Agency and regularly works 30 or more hours per week or a minimum of 1560 hours per year, and is considered a "full-time" employee as determined according to the relevant Member Agency's personnel policy,

(ii) When a Member Agency defines "full-time" as more than 30 hours per week, a Member Agency's Employee will be eligible if the Employee is directly employed by a Member Agency and regularly works the number of hours (or more) per week stated in the Member Agency's personnel policy to be considered "full-time," or

(iii) A Member Agency's Employee will be eligible if directly employed by a Member Agency and considered "full-time" as defined under the "Employer Shared Responsibility" rules established by the Affordable Care Act ("ACA"). (Under this last option, a Member Agency may consider an Employee "full-time" due to past service even if the person currently is not working full-time.)

Additionally, an Employee participating in the Illinois Municipal Retirement Fund (IMRF) or other similar pension plan who retires or becomes disabled as defined under the terms of IMRF or the other plan on or after January 1, 1991, and was covered under this Plan on the date immediately prior to his retirement or disability, also will be eligible for Plan coverage,

Seasonal or temporary employees cannot be considered Participants.

Eligibility

Each Participant who was covered under the employer's prior plan and who is actively at work on the effective date of this Plan, becomes eligible for Personal Benefits on the effective date of this Plan.

If the employee is not actively at work on the date of eligibility, coverage will be effective on the date the employee returns to active work and becomes eligible as a Participant.

Employees who have not satisfied their employer's waiting period but are actively at work on the effective date of this Plan become eligible as a Participant upon completing the employer's waiting period.

Employees hired on or after the effective date of this Plan become eligible as a Participant in accordance with the agreement between their respective Member Agency and the Plan.

A Participant cannot be covered simultaneously as an Employee and a Dependent

If an Employee does not enroll himself or himself and his Dependents within 31 days of the date eligible, he will not be eligible to enroll in the Plan until the Annual Open Enrollment Period or a Special Enrollment Period.

(1) New Hire Enrollment

An Employee hired on or after the effective date of this Plan becomes eligible for benefits after satisfying any applicable Waiting Period required by the Member Agency, provided that such Waiting Period may not exceed 90 calendar days from either (1) the Employee's date of hire or (2) the Employee's satisfaction of the Member Agency's

eligibility requirements specific to the job (such as licensing or training). However, in the case of an Employee who is considered to be a new "variable hour employee" as defined under the Affordable Care Act, coverage will begin no later than the first of the month after such Employee completes 13 months of employment.

Coverage for benefits becomes effective on the date the Employee is eligible for coverage provided the Employee has enrolled within 31 days of the date eligible.

Each Employee becomes eligible to cover his Dependents for benefits on the later of the following dates:

- the date he is eligible for benefits, if he then has a Dependent;
- the date he acquires his first eligible Dependent through marriage, civil union, birth, adoption, placement for adoption, legal guardianship, or meeting the Domestic Partner relationship requirements.

If an Employee does not enroll himself or himself and his Dependents within 31 days of the date eligible, he will not be eligible to enroll in the Plan until the Annual Open Enrollment Period or a Special Enrollment Period.

(2) Annual Open Enrollment

If the Employee enrolls during the annual Open Enrollment period held as determined by the Plan Administrator, coverage will be effective on the subsequent January 1st.

(3) Special Enrollment: Loss of Other Coverage/New Dependent

If an Employee experiences a loss of other health coverage, including COBRA Continuation Coverage, the existence of which was the reason for declining coverage under this Plan when first eligible to enroll, then the Employee may enroll for coverage within 31 days of the loss of such coverage. Loss of coverage means that COBRA Continuation Coverage has been exhausted or that coverage which was not under a COBRA Continuation provision has been terminated as a result of a loss of eligibility for the coverage or termination of employer contributions towards such coverage. Coverage will be effective on the date of the occurrence.

If an Employee declined coverage for his Dependents under this Plan when first eligible to enroll because his Dependents had other health coverage, including COBRA Continuation Coverage, and they experience a loss of the other health coverage as described above, the Employee may enroll for Dependent benefits within 31 days of the occurrence. Coverage will be effective on the date of the occurrence.

If an Employee acquires a Dependent through marriage, civil union or domestic partnership, the Employee may enroll for coverage within 31 days of the marriage, civil union or of the date that the requirements outlined for recognition of the domestic partnership are met. Coverage will be effective on the date of the marriage, civil union or the date the Domestic Partner requirements have been met.

If an Employee acquires a Dependent through birth, adoption or placement for adoption, the Employee may enroll for coverage within 31 days of the birth, adoption or placement for adoption. Coverage will be effective on the date of the acquisition.

If an Employee or the Employee's Dependents lost other coverage as a result of the failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), then a special enrollment right will not exist.

(4) Special Enrollment: Children's Health Insurance Program Reauthorization Act

If the Employee or his/her Dependent experience (1) a loss of eligibility for Medicaid or a state children's health insurance program (SCHIP), or (2) become eligible to participate in a premium assistance program under Medicaid or SCHIP, the Employee and/or his/her Dependent will be entitled to receive coverage under the Plan. Such enrollment must be requested within 60 days of the loss of such eligibility or becoming eligible for such premium assistance.

If an Employee or the Employee's Dependents lost other coverage as a result of the failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), then a special enrollment right will not exist.

(5) Special Disenrollment: Dependent Gains Other Coverage through Employment

An Employee may drop coverage mid-year (meaning other than at annual Open Enrollment) for himself and/or his Dependents if he and/or his Dependents become eligible for and enroll in coverage under another group health plan

due to the commencement of employment of a Dependent. A request for such a change must be made within 31 days of enrollment in the other group health plan, and this Plan may request proof of such enrollment.

B. PARTICIPANT ELIGIBILITY FOR DEPENDENT BENEFITS

When an Employee enrolls his Dependents and authorizes any required contributions for Dependent benefits, Dependent benefits will become effective as follows:

- If an Employee has eligible Dependents on the effective date of his coverage and he has enrolled for dependent benefits on or prior to the Employee's effective date, then coverage for those Dependents will be effective on the date the Employee's coverage begins.
- If an Employee does not have eligible Dependents on the effective date of his coverage and later acquires his first eligible Dependent(s), and if he enrolls for Dependent benefits within 31 days of the date of acquisition, then coverage for the Dependent(s) will be effective on the date of acquisition.

If the Employee is already enrolled for Dependent benefits, any newly acquired Dependents, including newborns, must be enrolled within 31 days of acquisition. Coverage will be effective on the date of acquisition.

Benefits will not become effective for the Dependents of an Employee unless the Employee is covered, or simultaneously becomes covered, for benefits. Under no circumstances will coverage for an Employee's Dependents occur prior to coverage for the Employee.

C. DEPENDENT ELIGIBILITY

A Dependent is:

- A Participant's Spouse
- A Participant's Civil Union Partner
- A Participant's Domestic Partner
- A Participant's Child :
 - o From birth until the date he attains age 26.
 - o Who was covered under the Plan prior to attaining age 26 (or who was continuously covered prior to attaining age 26 under another group health plan in which the Employee was participating immediately prior to becoming eligible for coverage under this Plan provided that the Employee enrolls such child in this Plan as soon as the Employee becomes eligible for coverage) and who is 26 years of age or older, and who, from the date his coverage would otherwise terminate under the Plan (or another group health plan) due to the attainment of age 26, is both

(a) incapable of engaging in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months and

(b) dependent upon the Employee for more than one-half of his/her financial support and maintenance. (Proof may be required.)

The Employer will have the right to require due proof of the continuation of the mental and/or physical impairment and will have the right and opportunity to examine the child whenever the Employer may reasonably require it during such continuation. After two years have elapsed from the date the child attained the limiting age, only one examination will be required per year.

- Who is a military veteran and who is at least 26 years of age and under 30, and is (a) unmarried and (b) resides with the Employee and (c) is principally dependent upon the Employee for over half his or her financial support and maintenance and (d) an Illinois resident. (Proof may be required.) To be considered a “military veteran” the child must have served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States; and has received a release or discharge, other than a dishonorable discharge.

TERMINATION OF COVERAGE

A. PARTICIPANT

The coverage of any Participant covered under the PDRMA plan document shall cease on the earliest of the following dates except as provided in the section entitled Continuation of Benefits (if applicable):

- The date this Plan terminates.
- The date ending the period for which any required contributions have been paid.
- The date determined by the plan due to an act of fraud or material misrepresentation committed by the Participant or his Dependent.
- The date the Participant is no longer eligible for coverage under this Plan.
- The date of the Participant's death.
- The date the Participant's employment terminates.
- The date the Participant elects in writing that termination of coverage occurs as long as the request is made within the appropriate timeframe of the event that allows for the change (see sections Annual Open Enrollment and Special Enrollments).
- The date he begins active duty in the Armed Forces of any country for longer than two weeks, except as specified under Continuation of Benefits, section C item 2 (ILLINOIS LOCAL GOVERNMENT EMPLOYEES BENEFITS CONTINUATON ACT).

If, subsequent to termination, a Participant is re-employed or reinstated by the same Member Agency as an eligible Participant, he/she will be treated in the same manner as a new Participant at the date of such reemployment or reinstatement.

B. DEPENDENT

Coverage with respect to each Dependent covered under this Plan shall cease on the earliest of the following dates except as provided in the section entitled Continuation of Benefits (if applicable);

- The date benefits cease for the Participant.
- The date such individual ceases to be a Dependent as defined in the PDRMA plan document.
- The date determined by the Plan due to an act of fraud or material misrepresentation committed by the Employee or the Dependent.
- The date the Participant's dependent spouse, Civil Union Partner, or Domestic Partner begins active duty in the Armed Forces of any country for longer than two weeks.
- The date for which written election of termination is received as long as the request is made within the appropriate timeframe of the event that allows for the change (see sections Annual Open Enrollment and Special Enrollments).
- The date ending the period for which any required contributions have been paid.

C. EXCEPTIONS

Cessation of active work shall result in termination of coverage, except that:

- If a Participant is absent from work because of sickness or injury, the coverage may be considered to continue until terminated by the Member Agency, but for no longer than 12 months from the start of the absence, provided the Participant makes any required contributions; or
- If a Participant is absent from work because of approved leave of absence, the coverage may be considered to continue until terminated by the Member Agency, but for no longer than 12 months from the date the leave started, provided any required contributions are made; or
- Coverage for Participants serving in the armed forces for a tour of duty, reserve call-up, or volunteer for service will be subject to applicable state and federal law for service in the Armed Forces of the United States. Participants must notify the Plan Administrator prior to any military leaves. Refer to section C item 2 for more details.

DENTAL BENEFITS

This Group Dental Plan will pay for those dental services or procedures listed in the Schedule of Dental Benefits. Benefit payments are subject to any applicable Deductible, waiting periods and coverage limits listed in the Dental Plan Specifications. The Dental Benefits furnished under this Group Dental Plan are limited and defined as set forth in the Schedule of Dental Benefits. A request for predetermination of plan benefits, accompanied by any required documentation, should be submitted to DDIL for payment determination before services are rendered. A determination made by DDIL imposes no restrictions on the method of diagnosis or treatment by a treating Dentist and only relates to the level of payment which this Group Dental Plan is required to make.

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

LEVEL OF DENTAL BENEFITS

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

REQUIRED DOCUMENTATION

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

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

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

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

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

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

GENERAL PROVISIONS

NOTICE AND PROOF OF DENTAL CLAIMS

Written notice and proof of claim is to be furnished to DDIL within 90 days after the Covered Individual has received a Dental Benefit. Failure to furnish this Proof of Claim within this 90-day time period shall not invalidate or reduce any claim if the Covered Individual provides a reasonable explanation of this failure to file a timely claim. IN NO EVENT WILL THE PLAN BE LIABLE FOR ANY NOTICE OR PROOF OF CLAIM WHICH IS SUBMITTED TO DDIL MORE THAN 15 MONTHS AFTER THE COVERED INDIVIDUAL HAS RECEIVED DENTAL SERVICES FOR THAT CLAIM. No action shall lie against The Plan unless, as a condition precedent thereto, the Covered Individual shall have fully complied with the notice and Proof of Claim provisions contained in this Dental Benefits Booklet.

COORDINATION OF BENEFITS

The provisions of this section (herein called "these provisions") are for coordination of all benefits under the PDRMA Plan with other benefit plans.

A. DEFINITION OF WORDS AND TERMS USED IN THIS SECTION

The word **Plan** means any plan providing benefits or services for dental care or treatment for which benefits or services are provided by:

- any group, franchise, hospital or medical service, prepayment or other coverage arranged through any employer, trustee, union, employee benefit or other employee association;
- any coverage under governmental programs, and any coverage required or provided by any statute;
- any coverage sponsored by, or provided through, a school or other educational institution;
- any group automobile insurance or individual automobile insurance, even if based on "no-fault" coverage.

The word **Plan** shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services (whether paid or not) of other Plans into consideration in determining its benefits.

The term **this Plan** means those sections of the PDRMA plan document or the Dental Benefits Booklet which provide the benefits that are subject to these provisions.

The term **Allowable Expense** means any necessary, reasonable, usual, and customary item of expense, at least a portion of which is covered under at least one of the Plans covering the individual for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

The term **Claim Determination Period** means, for any individual, that portion of a calendar year during which he/she would be eligible to receive benefits under the PDRMA plan document in the absence of this section.

B. EFFECT ON BENEFITS

If this is not your only dental coverage, the benefits payable under this Plan, and any other Plan for the allowable expense incurred during the claim determination period will be coordinated so that the combined benefits paid or provided by all Plans equal that amount which would be paid if this Plan was the only coverage.

You must notify the Claims Administrator if you have or obtain other coverage. When you file a claim, file it with the primary coverage (as determined below) first. When you receive the explanation of benefits from the primary coverage, submit a copy of the charges, and a copy of the explanation of benefits to the secondary Plan. This will expedite the processing of your claim.

One of your Plans will be determined to be primary using the rules below. The primary Plan pays its full benefits first. If this Plan is determined to be the secondary Plan, the benefits paid in addition to the benefits paid under the primary Plan will not be an amount more than the amount you would have received had this Plan been your only coverage.

For the purpose of these provisions, the rules establishing the order of benefit determination are:

1. the benefits of a plan which does not contain a Coordination of Benefits provision always shall be determined before the benefits of the plan which does contain a Coordination of Benefits provision;
2. the benefits of a plan which covers the individual as an active employee shall be determined before the benefits of a plan which covers such individual as a Dependent;
3. the benefits of a plan which covers the individual as a Dependent;
4. when two or more plans cover the same child as a Dependent of different parents, and the parents are not separated or divorced, benefits will be determined by the "birthday rule" in the following order:
 - the benefits of the Plan of the parent whose birthday, month and day only, falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday, month and day only, falls later in the calendar year;
 - if both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time are determined before those of the Plan which covered the parent for a shorter period of time;
 - however, if the other Plan does not use the "birthday rule," and as a result, the plans do not agree on the order of benefits, the provisions of the other plan shall determine the order of benefits;
5. if the parents are divorced or legally separated, it is necessary to determine if there is a court decree which establishes financial responsibility for medical, dental or other health care expenses for the child. If there is such a decree, the benefits of the plan covering the parent who has that responsibility shall be determined before the benefits of the plan covering the other parent;
6. if there is no such decree, the benefits of the plan covering the parent who has custody of the child shall be determined before the benefits of the plan covering the other parent;
7. if there is no such decree, and the parent with custody of the child has remarried, the order of priority is:
 - the plan covering the parent who has custody;
 - the plan covering the spouse of the parent who has custody (that is, the stepparent of the child); and
 - the plan covering the parent without custody.
8. when rules (1) through (7) in this section do not establish an order of benefit determination, the benefits of the plan which has covered the individual on whom the claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such individual for the shorter period of time.

If this Plan is determined to be secondary, the benefits payable will be reduced so that the combined benefits provided by all Plans during the claim determination period are not more than that amount which would have been paid if this was the only benefit Plan for the covered person. If benefits under this Plan are reduced because of the coordination of benefits, only the reduced amounts will be charged against any applicable benefit limit of this Plan.

C. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of these provisions under this Plan or any provision of similar purpose of any other plan, the Claims Administrator may, without the consent of or notice to any individual, release to or obtain from any insurance company or other organization or individual any information, with respect to any individual, which the Claims Administrator deems to be necessary for such purposes. Any individual claiming benefits under this Plan shall furnish to the Claims Administrator such information as may be necessary to implement these provisions.

D. FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with these provisions have been made under any other Plans, the Claims Administrator shall have the right, exercisable alone and at its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of these provisions, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the Claims Administrator shall be fully discharged from liability under this Plan.

E. RIGHT TO RECOVERY

Whenever payments have been made by the Claims Administrator with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of these

provisions, the Claims Administrator shall have the right to recover such payments on PDRMA's behalf, to the extent of such excess, from among one or more of the following, as the Claims Administrator shall determine: any individual to or for or with respect to whom such payments were made, any insurance companies, any other organizations.

DISPUTED CLAIMS PROCEDURE

(Notification of Initial Benefit Decision (Initial Adverse Benefit Decision))

DDIL shall decide the initial claim within a reasonable time but no later than 30 days after receipt of the completed claim. A complete claim has all the supporting documentation we require to make a decision. See the section entitled "Required Documentation." DDIL will screen and process all claims based on claim coverage guidelines approved by the Plan Administrator of your group dental program. If the claim is incomplete, DDIL may deny the claim.

DDIL will provide written notification of its decision unless DDIL issues payment in full. That notice shall include the reason(s) for the decision (a reference code provides the policy on which the decision is based or indicates material or information necessary to perfect the claim), a description of the Plan's review procedures and applicable time limits for appealing the decision, following an internal final adverse determination and the right to obtain information about those procedures. You have 180 days from the day you receive our notice to file an appeal.

Your Right to Appeal

If you have questions about this claim decision, you may contact DDIL's Customer Service Department at the telephone number listed on your Explanation of Benefits. Since most questions about benefits can be answered informally, we encourage you first try resolving any issues by talking with DDIL. Of course, you have the right to file an appeal requesting that we formally review the claim decision, without making an informal inquiry.

Under federal law, you are entitled to a full and fair review of the denied claim. Appeals must be made in writing within 180 days following receipt of DDIL's adverse benefit determination. The request must indicate your name and address, the specific basis for the request and any additional materials you wish to present. You should also include any documentation from your Dentist that would substantiate coverage of the denied claim. If you fail to comply with this deadline you may forfeit any right to any further review of an adverse decision under these procedures or in a court of law.

How to file a Request For External Review

If you have exhausted the required internal appeal process as described above, you may file a request for an independent external review. See procedures below. The request must be in writing and submitted within four months of the notice of denial of coverage or payment. That request is to be filed with the Plan Administrator with a copy to DDIL, 111 Shuman Boulevard, Naperville, Illinois 60563, Attention: Request for External Review. You may submit additional information for this external review.

On behalf of the Plan Administrator, DDIL shall assign an independent review organization that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. The assigned IRO will provide written notice of the final external review decision within 45 days after it receives the request for the external review.

The decision of the IRO is binding except to the extent that other remedies are available by law.

How your Appeal Will Be Decided

DDIL's Reevaluation Committee will review your claim and will furnish you with a notice of decision within **30 days** of receiving the request for review. Upon request and free of charge, you will be provided copies of all documents, records and other information relevant to your claim. The person who reviews and decides an appeal will be a different individual than the person who made the initial benefit decision and will not be a subordinate of

the person who made the initial benefit decision. The review will take into account all information you submit whether or not presented or available at the initial benefit decision.

DDIL will provide written notification of its decision regarding your appeal including the reason(s) for the decision (a reference code provides the policy on which decision is based) and a notation that you may have the right to an external appeal through an independent agency, known as an independent review organization (“IRO”).

External Appeal Process

If you have exhausted the required internal appeal process described above, you or your authorized representative, may request an independent external review of the denied procedures or services in question if the claim determination involves medical judgment or a rescission of coverage by making written request to DDIL within four (4) months of receipt (excluding appeals that involve only contractual or legal interpretation without any need for medical judgment) of its notification via the “Explanation of Decision on Appeal” also referred to as the “Final Internal Adverse Benefit Determination.” Medical judgment includes, but is not limited to:

1. Medical Necessity;
2. Appropriateness;
3. Experimental or Investigational treatment;
4. Health care setting;
5. Level of care; and
6. Effectiveness of a covered expense.

If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. *{Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1 falls on a Saturday, Sunday or Federal holiday.}*

Plan Administrator (or its designee) will perform a preliminary review of the request within five (5) business days of receipt of the request, to determine if the request is eligible for external review, based on confirmation that:

1. The covered person incurring the claim is or was covered under the Plan at the time the procedure or service was provided;
2. The final internal adverse benefit decision does not relate to the covered person’s failure to meet Plan eligibility requirements;
3. The covered person has exhausted the Plan’s appeal process, to the extent required by law; and
4. The covered person has provided all of the information and forms required to complete an external review.

The Plan Administrator (or its designee) shall notify you within one business day after completion of this preliminary review advising as to whether your request is eligible for external review or if further information or documents are needed. Once an eligible request for external review is complete, DDIL will assign the matter to an Independent Review Organization (“IRO”).

Notice of Right to External Appeal

The Plan Administrator (or its designee) shall provide you (or your authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

Expedited External Review

You may seek expedited external review in certain circumstances where any delay in issuing a benefit determination would seriously jeopardize your life, health or your ability to regain maximum function.]. Upon receipt of the request for expedited external review, DDIL will immediately notify you whether the request is complete and eligible for external review. If the claim is eligible for an expedited external review, we will assign the claim to an IRO and provide it with all relevant information. The IRO process will be equivalent to a standard review, but must be completed as quickly as circumstances require but no later than 72 hours after the IRO receives the review request.

Notice of Rights When Appeal is Not Eligible for External Review

The Plan offers the following voluntary appeal process for claims that are not eligible for external review and not related to Plan eligibility (*i.e.*, non-medical judgment claims). ***A Participant must have exhausted the appeal process set forth above before filing an appeal under this voluntary appeal process.*** Unless otherwise set forth below, there is no cost to the Participant under this voluntary appeal process.

1. APPEAL TO THE HEALTH PROGRAM DIRECTOR

If the Participant receives a *Notice of Right to External Appeal* stating that his claim is not eligible for external review, the Participant may file an appeal in writing to the Health Program Director at 2033 Burlington Avenue, Lisle, IL 60532-1646 within thirty (30) days of receiving the *Notice of Right to External Appeal*. The Participant should provide the Health Program Director any information relevant to the claim on appeal. A written response will be issued to the Participant within thirty (30) calendar days of receipt, and if the Participant's appeal is denied, instructions regarding the next step in the voluntary appeal process will be provided.

2. APPEAL TO THE HEALTH BENEFITS COMMITTEE

If the Participant is dissatisfied with the Health Program Director's decision, an appeal may be made in writing to the Health Benefits Committee by mailing the written appeal to the President/Chief Executive Officer at 2033 Burlington Avenue, Lisle, IL 60532-1646. Appeals should be made within thirty (30) days of the postmarked date on which the decision of the Health Program Director was mailed to the Participant.

The Health Benefits Committee will consider appeals within thirty (30) days of the postmark of the appeal notice and the Participant may request a hearing (such request to be granted at the Health Benefits Committee's discretion). The Participant will be notified in writing of the date, time and place of the hearing at least ten (10) days in advance. The Participant may have witnesses testify on his behalf, and, at the sole discretion of the Health Benefits Committee, may be represented by legal counsel at the hearing. However, the Participant will be responsible for his own legal counsel's fees, as well as any costs related to any witnesses he calls to testify. Presentations, including those of the witness(es) will be limited to a total of 60 minutes.

The Health Benefits Committee may elect to continue the claim appeal hearing to a future date if additional time is required to obtain information not presented at the initial hearing. The Health Benefits Committee is not obligated to continue the hearing date to allow the Participant to submit additional evidence. The Health Benefits Committee will render its decision in writing to the Participant postmarked within ten (10) business days after the conclusion of any hearing held before it or if no hearing is provided, postmarked no later than thirty (30) days after the postmarked appeal notice from the Participant.

3. APPEAL TO THE PDRMA BOARD OF DIRECTORS

The Participant may appeal the Health Benefits Committee's decision to the PDRMA Board of Directors. Such request must be in writing and addressed to the Chairman of the Board of Directors at the PDRMA offices at 2033 Burlington Avenue, Lisle, IL 60532-1646 and postmarked within fourteen (14) days of the postmark of the letter by which the Participant was notified of the Health Benefits Committee's decision. The Board of Directors will consider such requests within thirty (30) days of the postmark of the request. The Participant may ask that a hearing be held (such request to be granted at the Board of Director's discretion). The Participant will have a full opportunity to present its position and, at the sole discretion of the Board of Directors, be represented by legal counsel at such hearing. However, the Participant will be responsible for his own legal counsel's fees as well as any costs related to any witnesses he calls to testify. The Board of Directors will render its decision in writing to the Participant postmarked within ten (10) business days after any hearing held before it or if no hearing is provided, postmarked no later than thirty (30) days after the postmark of the Participant's request for appeal. The decision of the PDRMA Board of Directors will be final.

NOTE: If the participant chooses, he may skip this voluntary appeal process and pursue his non-medical judgment claim in court upon completion of the first level of appeal. Furthermore, the Plan agrees that any statute of limitations or other defense based on timeliness is extended while the voluntary appeal process is pending. The decision of a Participant as to whether to submit a benefit dispute to the voluntary appeal process will have no effect on the Participant's rights to any other benefits under the Plan.

A Participant who requests an appeal under the voluntary appeal process may request information to assist in his decision to submit a benefit dispute to the voluntary appeal process, including information related to the Participant's right to representation, the process for selecting the decision maker(s), and the circumstances, if any, that may affect the impartiality of the decision maker(s), such as any financial or personal interests in the result or any past or present relationship with any party to the voluntary appeal process.

CONTINUATION OF BENEFITS

Note: The following coverage, or comparable coverage voluntarily provided by the Plan, is extended as applicable to all Participants, including Civil Union Partners, Domestic Partners and their children.

Federal Legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended (COBRA) requires that an Employee and/or Dependent may elect to continue coverage up to the length of time specified below after the occurrence of any of the following events which would normally result in termination of coverage under the Plan, provided they pay the full cost of Plan coverage, not to exceed 102% of the total cost (Employer and Employee) or 150% of the total cost during the 11-month extension for disability.

Each Qualified Beneficiary, including the Employee, spouse or any Dependent covered under the regular Plan, may make an independent election for Continuation coverage.

Coverage may be continued up to 18 months for an Employee and/or Dependent in the qualifying event of the termination of employment (other than by reason of gross misconduct) or the reduction of hours of an Employee. Continuation coverage may be extended from 18 months to 36 months for Dependent(s) who are qualified beneficiaries if during the 18-month period a second qualifying event occurs, such as the Employee dies, enrolls in Medicare, or divorces his spouse or dissolves his Civil Union Partnership, or terminates a domestic partnership. This extension may also apply upon the loss of Dependent status by a Dependent child. However, the extension is available only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Continuation coverage may extend from 18 months to 29 months for an Employee and/or Dependent who is or becomes totally disabled (as determined by the Social Security Administration under Title 2 or Title 16) at any time during the first 60 days of COBRA continuation coverage, provided that such Employee and/or Dependent has given notice of the disability within 60 days of the Social Security determination and requested the extended continuation period before the end of the first 18

months. If during the continuation coverage the qualified beneficiary is later determined by the SSA to be no longer disabled, the individual must inform the Plan of this redetermination within 30 days of the date it is made.

Coverage may be continued for up to 36 months for a Dependent in the qualifying event of:

- (a) The death of the Employee;
- (b) The divorce of the Employee from his spouse or dissolution of the Employee's Civil Union;
- (c) The termination of a Domestic Partner relationship;
- (d) The Employee's becoming entitled to Medicare, and as a result the loss of eligibility for coverage under the Plan by him and his Dependents;
- (e) The loss of Dependent status by a Dependent child under the terms of this Plan.

Any period of extended coverage a Participant is entitled to pursuant to the provisions of Section VI. F below, USERRA, and/or COBRA will run concurrently and not consecutively.

Coverage will be continued only for those Employees and/or Dependents who were covered under the Plan on the day immediately preceding termination. However, if a child is born or placed for adoption with the Participant during the period of COBRA continuation coverage, such child is entitled to receive COBRA continuation coverage with independent COBRA rights.

Coverage will not be continued beyond the earliest of the following dates:

- (a) The date ending the period for which any required contribution has been paid;
- (b) The date the Employee and/or Dependent first become entitled to Medicare, or first becomes covered under another group health plan without being subject to that plan's preexisting limitations;
- (c) The date the Employer ceases to provide any group health plan.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Member Agencies, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee is a qualified beneficiary with respect to the bankruptcy. The retired Employee's spouse, Civil Union Partner, Domestic Partner, surviving spouse, and Dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

If any provision of this section is contrary to the Consolidated Omnibus Reconciliation Act of 1985 (as amended), the provision is hereby automatically changed to comply with the law.

Note: All Plan Participants must notify the Plan in writing within sixty (60) days of:

- (a) Divorce or dissolution of a Civil Union
- (b) Termination of a Domestic Partner relationship
- (c) Covered Dependent child ceasing to qualify as a Dependent
- (d) Acceptance of Medicare or coverage under another employer's group health plan (whether or not as an Employee), if that plan does not limit coverage for preexisting conditions.
- (e) Second qualifying event
- (f) Qualified Beneficiary's disability
- (g) Death of the Employee
- (h) Qualified Beneficiary's cessation of disability (Note: all Plan Participants must notify the Plan in writing within thirty (30) days of cessation of disability)

Written notice must be provided to Plan Sponsor. The notice must include the name of the Employee with identification number, Plan Name and Number, date and type of the qualifying event and name(s) of the applicable Dependent(s).

FAILURE TO NOTIFY THE PLAN IN A TIMELY MANNER WILL RESULT IN LOSS OF ELIGIBILITY FOR COBRA CONTINUATION COVERAGE.

Notification Responsibilities

Under the law, the Employee or a Family member is responsible to notify the PDRMA Health Program, the Plan Administrator,

of a divorce, or loss of Dependent status (as defined in the Plan Document) within 60 days of whichever is later: the date of the event or the date coverage will be lost because of the event. Likewise, the PDRMA Health Program requires the employee or a Family member to notify the Program of dissolution of a civil union or termination of a domestic partner relationship within 60 days of the later of the date of the event or the date coverage will be lost because of the event. If this notification is not completed in a timely manner, then rights to continuation of coverage will be forfeited. Please check with the Employer's benefit coordinator for the notification procedure.

The Employee is also responsible to notify the Plan Administrator or the Employer of any address changes. All correspondence concerning COBRA will be mailed to the last known address. Failure to notify of an address change may delay notifications and possibly forfeit the right to continuation coverage.

Election Period

Complete instructions on COBRA, including a quote and the election form will be provided to Qualified Beneficiaries upon notification of the occurrence of a Qualifying Event. Under COBRA, Qualified Beneficiaries have 60 days from the later of (i) the date coverage was lost due to a Qualifying Event or (ii) the date notification of rights to continuation coverage is sent to inform the Plan Administrator of election for continuation coverage. Each Qualified Beneficiary has individual independent election rights under COBRA. If a Qualified Beneficiary waives the continuation coverage, the waiver can be revoked at any time before the end of the election period. An election can be made on behalf of the Qualified Beneficiary by a third party. If continuation coverage is not elected within the election period, rights to continuation coverage will end, and no coverage will be provided as of the Qualifying Event.

Benefits

Qualified Beneficiaries are entitled to coverage that is identical to coverage provided under the Plan to similarly situated active Employees. Qualified Beneficiaries do not have to show evidence of insurability to elect continuation coverage. However, continuation coverage under the law is provided subject to eligibility for coverage under the Plan. The PDRMA Health Program reserves the right to terminate continuation coverage retroactively to the Qualifying Event if the Qualified Beneficiary is determined to be ineligible.

Premiums and Payment Grace Periods

Qualified Beneficiaries are responsible for paying the entire applicable premium, however, anyone may make payment on behalf of a Qualified Beneficiary. The Plan may impose up to an additional 2% administration charge for continuation coverage. In addition, during an 11-month disability extension, the Plan may charge a premium equal to 150% of the cost of coverage under the group health plan.

The PDRMA Health Program will include monthly premium rates and payment due dates in the COBRA election notice that it provides to Qualified Beneficiaries upon receipt of notice of a Qualifying Event. COBRA law provides an initial grace period of 45 days from the date of election in which to make the first premium payment. This first payment must include all applicable retroactive premiums. Failure to make the first premium payment on a timely basis will cause coverage to terminate, even though elected, retroactive to the Qualifying Event. Further regularly scheduled monthly premium payments (other payment intervals such as weekly, quarterly or semi-annually are permissible) must be received by PDRMA postmarked within 30 days of the due date.

Failure to make timely payments results in a forfeiture of coverage. If coverage is forfeited, it will terminate retroactive to the end of the last period for which payment was timely received. If a check is received in a timely manner, and subsequently is returned "NSF" non-sufficient funds, the PDRMA Plan Administrator will allow the individual 10 calendar days to make payment by money order or cashier's check. This payment must include the regular premium amount, plus the bank's NSF fee. PDRMA will require that all further payments be made by money order or cashier's check; personal checks will no longer be accepted.

Uniformed Services Employment and Reemployment Rights Act – (USERRA)

USERRA was enacted in 1994 to minimize the disadvantages of military service to civilian careers and employment. It was designed to guarantee that those who perform voluntary or involuntary service in the uniformed service retain their civilian employment and benefits. To this end, USERRA provides that "in any case in which a person (or the person's Dependents) has coverage under the health plan in connection with the person's position of employment...and such person is absent from such position of employment by reason of service in the uniformed services, the Plan shall provide that the person may elect to continue such coverage..." (USERRA Section 4317(a)).

If the Employer does not have a policy of offering an extension of coverage for the Employee and his/her covered Dependents during a military leave of absence, there is a COBRA qualifying event. Alternatively, if the Employer does offer an extension of coverage during a military leave, there will be a COBRA qualifying event following the expiration of that extension. In accordance with USERRA, an Employee who goes on unpaid military leave of absence may continue to participate in this Plan during the USERRA leave until the earlier of:

- The 24 month period beginning on the date on which the Employee's absence begins; or
- The period ending on the day after the date on which the Employee fails to apply for or return to a position of employment with the Employer, as determined in accordance with USERRA

Any period of extended coverage a Participant is entitled to pursuant to the provisions of Section VI. F below, USERRA, and/or COBRA will run concurrently and not consecutively.

USERRA continuation coverage must be elected within the 60-day period following the Employee's loss of coverage under the Employer's group health plan due to entry in to military service.

Premiums for health plan continuation coverage elected under USERRA cannot exceed 102% of the full premium under the Plan. However, the Employer cannot require payment for such coverage for more than the Employee share, if any, for a person who performs services for less than 31 days.

Premiums may, at the payer's election, be made in monthly installments. Monthly premium payments must be received by PDRMA postmarked within 31 days of the due date. Failure to make timely payments results in a forfeiture of coverage. If coverage is forfeited, it will terminate retroactive to the end of the last period for which payment was timely received.

Unlike COBRA, USERRA does not require an election notice, or any other type of notice, advising the Employee of his/her rights. Therefore, it is incumbent upon the Employee to provide notice to his Employer and/or the Plan Administrator of his/her intention to apply for USERRA benefits.

If the Employee becomes reemployed by their previous Employer, then the coverage will be effective without the application of a Waiting Period (though no coverage is provided for service-related illnesses or injuries) for the Employee and his/her Dependents.

Illinois Local Government Employees Benefits Continuation Act

A covered Employee's medical coverage may be extended under the Illinois Local Government Employees Benefits Continuation Act (the "Illinois Act") if he or she is a member of any reserve component of the U.S. Armed Services, including the Illinois National Guard, and is mobilized to active duty as a result of an order of the President. Such a covered Employee may continue coverage under the Plan that he or she was receiving immediately prior to the date he or she is mobilized, as adjusted from time to time for similarly situated active Employees. Continued coverage under this Section will be provided only as required under the Illinois Act. Any period of extended coverage a Participant is entitled to pursuant to the Illinois Act, USERRA, and/or COBRA will run concurrently and not consecutively.

IMRF or Similar Pension Plan Continuation Coverage

An Employee who is eligible for a pension from the Illinois Municipal Retirement Fund (IMRF), or with respect to employees of a Member Agency whose employees do not participate in IMRF, the pension plan of the Member Agency ("similar pension plan") at the time of retirement through normal procedures or through ERI (Early Retirement Incentive), an Employee who is eligible for disability benefits under IMRF or a similar pension plan, or in some instances the surviving spouse or Civil Union Partner of a retired or disabled Employee, may elect to continue the group health benefits provided by the Employer as detailed below. IMRF or similar pension plan Continuation Coverage will end (based on the classification as a retiree, disabled member or surviving spouse/Civil Union Partner) as follows:

Retirees - If the Employee is a retiree, coverage will end when the first of the following events occur:

- The retiree again becomes an active participant in IMRF or similar pension plan.
- The retiree is convicted of an IMRF job related felony.

- The retiree dies.
- The retiree becomes eligible for Medicare. (Notwithstanding the preceding, the non-Medicare eligible covered spouse, Civil Union Spouse, or Domestic Partner of a retiree will be able to continue coverage beyond the date the retiree becomes eligible for Medicare until he or she becomes eligible for Medicare.)
- The date the retiree fails to pay premium.
- The date the Employer ceases to provide any group health plan to Employees.

Disabled Employee - If the Employee is disabled, coverage will end when the first of the following events occur:

- The disabled member becomes an active participant in IMRF or similar pension plan.
- The disabled member is convicted of an IMRF job related felony.
- The disabled member dies.
- The disabled member turns 65. (Notwithstanding the preceding, the non-Medicare eligible covered spouse, Civil Union Partner, or Domestic Partner of a disabled member will be able to continue coverage beyond the date the disabled member turns 65 until he or she becomes eligible for Medicare.)
- The disabled member takes a separation refund.
- The date the disabled member fails to pay premium.
- The date the Employer ceases to provide any group health plan to Employees.

Surviving Spouses - If the Participant is a Surviving Spouse or surviving Civil Union Partner of a covered retiree or disabled Employee and is receiving a Surviving Spouse pension, coverage will end when the first of the following events occur:

- The date the Surviving Spouse or Civil Union Partner becomes eligible for Medicare.
- The date the Surviving Spouse or Civil Union Partner dies.
- The date the Surviving Spouse or Civil Union Partner fails to pay premium.
- The date the Employer ceases to provide any group health plan to active Employees.
- The date the Surviving Spouse or Civil Union Partner no longer receives Surviving Spouse pension benefits.

Dependents - Dependent coverage may only be continued if the Employee's coverage is continued except in the instance of a Surviving Spouse or surviving Civil Union Partner who has an independent right to continue. Dependents coverage generally ends on the same date the Employee's coverage ends (except for a Surviving Spouse) as described above. However, as noted above, a non-Medicare eligible spouse, Civil Union Partner, or Domestic Partner may continue coverage beyond the date a retiree loses coverage due to Medicare eligibility or a disabled member loses coverage due to turning age 65 until he or she becomes him/herself eligible for Medicare. Coverage will be continued only for those Participants that were covered under the Plan on the day immediately preceding the retirement.

SUMMARY OF DENTAL PLAN BENEFITS - PLANS I AND II

PLAN I - DENTAL ONLY

Dental Benefits	In-Network Delta Dental PPO	Maximum Payable In-Network Delta Dental Premier	Out-of-Network
Deductible - single/family (applies to Basic and Major Services, general anesthesia and intravenous sedation)	\$25/\$75	\$50/\$150	\$50 per individual
Maximum Annual Benefit per Covered Individual per Calendar Year (applies to all covered services)	\$2,000	\$2,000	\$1,200
Coverage Percentage for:			
Preventive Services	100%	100%	90%
Basic Services	80%	80%	70%
Major Services	70%	70%	50%

PLAN II - DENTAL AND ORTHODONTIA

Dental Benefits	In-Network Delta Dental PPO	Maximum Payable In-Network Delta Dental Premier	Out-of-Network
Deductible - single/family (applies to Basic and Major Services, general anesthesia and intravenous sedation)	\$25/\$75	\$50/\$150	\$50 per individual
Maximum Annual Benefit per Covered Individual per Calendar Year (applies to all covered services excluding orthodontia)	\$2,000	\$2,000	\$1,200
Coverage Percentage for:			
Preventive Services	100%	100%	90%
Basic Services	80%	80%	70%
Major Services	70%	70%	50%
Orthodontia Benefits (for dependent children under age 19)			
Maximum Lifetime Benefit	\$2,000	\$2,000	\$1,000
Coverage Percentage	50%	50%	50%

APPENDIX A
SCHEDULE OF DENTAL BENEFITS

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

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

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

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

(1) If the Non-Delta Dental PPO Dentist is a Delta Dental Premier Dentist, the Dentist is bound to accept DDIL's Approved Fee as full reimbursement for his/her services after this Group Dental Plan's benefit payment.

(2) If the Non-Delta Dental PPO Dentist is not a Delta Dental Premier Dentist, the Dentist may bill the patient the difference, if any, between his/her fee and this Group Dental Plan's benefit payment.

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

NOTE: Services not available from an in-network provider within 30 miles of the Participant's residence will be payable subject to the in-network deductible, coinsurance and maximum annual benefit. Payment will be based upon the Delta Dental of Illinois Approved Fee. See language at the beginning of the Schedule of Benefits for information about the Approved Fee.

**APPENDIX A
SCHEDULE OF DENTAL BENEFITS**

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

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	100%	100%	90%	N	N	N
Comprehensive oral evaluation – new or established patient: <i>once per Dentist.</i>	100%	100%	90%	N	N	N
Detailed and extensive oral evaluation – problem focused, by report: <i>once per Dentist.</i>	100%	100%	90%	N	N	N
Comprehensive periodontal evaluation – new or established patient: <i>once per Dentist.</i>	100%	100%	90%	N	N	N
Periodic oral evaluations: <i>twice per calendar year</i>	100%	100%	90%	N	N	N
Intra-oral – periapical radiographs	100%	100%	90%	N	N	N
Bitewing x-rays: <i>twice per calendar year</i>	100%	100%	90%	N	N	N
Complete full mouth x-rays: <i>once in a 36-month interval.</i> <i>A full mouth x-ray includes bitewing x-rays.</i> <i>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.</i> <i>One full-mouth x-ray or one panoramic x-ray is a covered benefit in a 36-month interval.</i>	100%	100%	90%	N	N	N
Diagnostic casts: <i>when rendered more than 30 days prior to definitive treatment.</i>	100%	100%	90%	N	N	N
Pulp vitality tests: <i>once per visit</i>	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.

Co-Payment Percentage

Deductible Applies

Procedure	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network
PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): twice per calendar year*	100%	100%	90%	N	N	N
Topical fluoride applications: twice per calendar year	100%	100%	90%	N	N	N
Space maintainers: once per lifetime for dependent children under age 19.	100%	100%	90%	N	N	N
Recementation of space maintainers: once per lifetime for dependent children under age 19	100%	100%	90%	N	N	N
Sealants: applied once per calendar year to first and second permanent molars which are free of caries (cavities) and restorations; for dependent children under age 19	100%	100%	90%	[Y/N]	[Y/N]	[Y/N]

*With an indicator for diabetes, high risk cardiac conditions, kidney failure or dialysis conditions, or special healthcare needs, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year.

*With an indicator for periodontal disease, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.

*With an indicator for suppressed immune system conditions or cancer-related chemotherapy and/or radiation, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.

*With an indicator for pregnancy, the enrollee will be eligible for one additional cleaning (prophylaxis or periodontal maintenance) during the time of pregnancy.

RESTORATIVE SERVICES

Amalgam and resin-based composite fillings once per surface in a 12-month interval. <i>When multiple restorations involving the proximal and occlusal/incisal surfaces are requested or performed on the same tooth, the level of benefits will be limited to that of one multi-surface restoration</i>	80%	80%	70%	Y	Y	Y
Onlays (permanent teeth only)	70%	70%	50%	Y	Y	Y
Crowns and ceramic restorations (permanent teeth only)	70%	70%	50%	Y	Y	Y
Recementation of inlays, onlays, partial coverage restorations, cast or prefabricated posts and cores and crowns	70%	70%	50%	Y	Y	Y
Prefabricated stainless steel crowns	70%	70%	50%	Y	Y	Y
Sedative filling	70%	70%	50%	Y	Y	Y
Pin retention	70%	70%	50%	Y	Y	Y
Cast or prefabricated post and core: core build-up	70%	70%	50%	Y	Y	Y
Additional procedures to construct new crown under existing partial denture framework	80%	80%	70%	Y	Y	Y

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

When a cast restoration with a cosmetic component is required or performed on a molar other than an upper first molar, the level of benefits will be limited to that of a cast metal restoration.

When the retentive quality of a tooth does not qualify for a cast restoration (radiographic evidence of decay or missing tooth structure on less than four surfaces). The level of benefits will be limited to that of an amalgam or resin restoration

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

When a porcelain/ceramic only is requested or placed, the level of benefits will be limited to that of a cast metal only.

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

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

ENDODONTIC SERVICES						
Pulpal and root canal therapy	80%	80%	70%	Y	Y	Y

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

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

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

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

SURGICAL PERIODONTIC SERVICES						
Gingivectomy or gingivoplasty: gingival flap procedure	N/A	N/A	N/A	N/A	N/A	N/A
Clinical crown lengthening - hard tissue	80%	80%	70%	Y	Y	Y
Osseous surgery (including flap entry and closure)	N/A	N/A	N/A	N/A	N/A	N/A
Guided tissue regeneration, per site: only when performed in association with natural teeth	80%	80%	70%	Y	Y	Y
Bone replacement grafts	N/A	N/A	N/A	N/A	N/A	N/A
Soft tissue grafts	80%	80%	70%	Y	Y	Y

N/A - Please refer to your medical plan regarding coverage for these procedures.

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

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

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

Bone replacement grafts performed in conjunction with extractions or implants are not a covered benefit

**With an indicator for diabetes, high risk cardiac conditions, kidney failure or dialysis conditions, or special healthcare needs, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year.*

**With an indicator for periodontal disease, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.*

**With an indicator for suppressed immune system conditions or cancer-related chemotherapy and/or radiation, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.*

**With an indicator for pregnancy, the enrollee will be eligible for one additional cleaning (prophylaxis or periodontal maintenance) during the time of pregnancy.*

REMOVABLE PROSTHODONTIC SERVICES						
Complete and partial dentures	70%	70%	50%	Y	Y	Y
Adjustments to complete and partial dentures	80%	80%	70%	Y	Y	Y
Repairs to complete and partial dentures	80%	80%	70%	Y	Y	Y
Replace missing or broken teeth	80%	80%	70%	Y	Y	Y
Add tooth or clasp to existing partial denture	80%	80%	70%	Y	Y	Y
Replace all teeth and acrylic on cast metal framework	70%	70%	50%	Y	Y	Y
Denture rebase: <i>once in a 24-month interval.</i>	70%	70%	50%	Y	Y	Y
Denture reline: <i>once in a 24-month interval.</i>	70%	70%	50%	Y	Y	Y

FIXED PROSTHODONTIC SERVICES (BRIDGES)						
Pontics	70%	70%	50%	Y	Y	Y
Fixed partial denture retainers - inlays/onlays (inlays/onlays placed as abutments, i.e., to retain or support fixed partial dentures)	70%	70%	50%	Y	Y	Y
Fixed partial denture retainers – crowns (crowns placed as abutments, i.e., to retain or support fixed partial dentures)	70%	70%	50%	Y	Y	Y
Recement fixed partial denture	70%	70%	50%	Y	Y	Y
Cast or prefabricated post and core; core build-up	70%	70%	50%	Y	Y	Y

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

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

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

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

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

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

ORAL SURGERY						
Simple extractions	80%	80%	70%	Y	Y	Y
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	80%	80%	70%	Y	Y	Y
Removal of impacted tooth – soft tissue	80%	80%	70%	Y	Y	Y
Removal of impacted tooth – partially bony	80%	80%	70%	Y	Y	Y
Removal of impacted tooth – completely bony	N/A	N/A	N/A	N/A	N/A	N/A
Removal of residual tooth roots (cutting procedure)	N/A	N/A	N/A	N/A	N/A	N/A
Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus	80%	80%	70%	Y	Y	Y
Surgical access of an unerupted tooth	80%	80%	70%	Y	Y	Y
Biopsy of oral tissue: brush biopsy	N/A	N/A	N/A	N/A	N/A	N/A
Surgical repositioning of teeth	N/A	N/A	N/A	N/A	N/A	N/A
Alveoloplasty - per quadrant	N/A	N/A	N/A	N/A	N/A	N/A
Vestibuloplasty - ridge extension	80%	80%	70%	Y	Y	Y
Surgical excision of soft tissue lesions	80%	80%	70%	Y	Y	Y
Incision and drainage of abscess - intraoral soft tissue	N/A	N/A	N/A	N/A	N/A	N/A
Surgical excision of intra-osseous lesions	N/A	N/A	N/A	N/A	N/A	N/A
Other covered surgical/repair procedures: removal of exostosis, torus palatinus or torus mandibularis; frenulectomy or frenuloplasty; excision of hyperplastic tissue or pericoronal gingiva; surgical reduction of osseous or fibrous tuberosity.	80%	80%	70%	Y	Y	Y

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

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

N/A - Please refer to your medical plan regarding coverage for these procedures. These services will be covered as Basic procedures at 80% in-network and 70% out-of-network, subject to deductible and the Annual Maximum Benefit when the PDRMA medical HMO plan excludes coverage.

ADJUNCTIVE GENERAL SERVICES						
Palliative (emergency) treatment of dental pain - minor procedure	100%	100%	90%	N	N	N
Deep sedation/general anesthesia: when provided by a dentist in conjunction with Oral Surgery (surgical procedures) other than simple extractions.	80%	80%	70%	Y	Y	Y
Intravenous conscious sedation/analgesia: when provided in conjunction with Oral Surgery (surgical procedures) other than simple extractions.	80%	80%	70%	Y	Y	Y
Consultations	100%	100%	90%	N	N	N

OTHER						
Occlusal guard once in a 5-year interval	100%	100%	90%	N	N	N
Fabrication of athletic mouthguard once in a 5-year interval	100%	100%	90%	N	N	N
Repair and/or reline of occlusal guard	100%	100%	90%	N	N	N
Nitrous oxide	80%	80%	70%	Y	Y	Y
Therapeutic drug injection	70%	70%	50%	Y	Y	Y
Implants	70%	70%	50%	Y	Y	Y

PLAN I

ORTHODONTIC SERVICES						
Treatment necessary for the proper alignment of teeth	N/A	N/A	N/A	N/A	N/A	N/A

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

PLAN II

ORTHODONTIC SERVICES						
Treatment necessary for the proper alignment of teeth, for dependent children under age 19.	50%	50%	50%	N	N	N

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

APPENDIX B **EXCLUSIONS**

EXCLUSIONS THAT APPLY TO DIAGNOSTIC SERVICES:

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

EXCLUSIONS THAT APPLY TO PREVENTIVE SERVICES:

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

EXCLUSIONS THAT APPLY TO RESTORATIVE SERVICES:

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

EXCLUSIONS THAT APPLY TO ENDODONTIC SERVICES:

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

EXCLUSIONS THAT APPLY TO PERIODONTIC SERVICES:

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

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

EXCLUSIONS THAT APPLY TO PROSTHODONTIC SERVICES:

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

EXCLUSIONS THAT APPLY TO ORAL SURGERY:

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

GENERAL EXCLUSIONS THAT APPLY TO ALL PROCEDURES:

Coverage is NOT provided for:

- Services compensable under Worker's Compensation or Employer's Liability laws.
- Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges which the person is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its Amendments.
- Services performed to correct developmental malformation including, but not limited to, cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis and congenitally missing teeth. This exclusion does not apply to *newborn infants*.
- Services performed for purely cosmetic purposes, including, but not limited to, tooth-colored veneers, bonding, porcelain restorations and microabrasion. Orthodontic care benefits shall fall within this exclusion unless such benefits are provided by endorsement.
- Charges for services completed prior to the date the person became covered under this program.
- Services for anesthetists or anesthesiologists.
- Temporary procedures.
- Any procedure requested or performed on a tooth when radiographs indicate that less than 40% of the root is supported by bone.
- Services performed on non-functional teeth (second or third molar without an opposing tooth).

- Services performed on deciduous (primary) teeth near exfoliation.
- Drugs or the administration of drugs, except for general anesthesia, intravenous conscious sedation, nitrous oxide and therapeutic drug injection.
- Procedures deemed experimental or investigational by the American Dental Association, for which there is no procedure code, or which are inconsistent with Current Dental Terminology coding and nomenclature.
- Services with respect to any disturbance of the temporomandibular joint (jaw joint).
- Procedures that Delta Dental considers to be included in the fees for other procedures. For such procedures, a separate payment will not be made by this group dental plan. A Dentist in the Delta Dental PPO or Delta Dental Premier network may not bill the patient for such procedures.
- The completion of claim forms and submission of required information, not otherwise covered, for determination of benefits.
- Infection control procedures and fees associated with compliance with Occupational Safety and Health Administration (OSHA) requirements.
- Broken appointments.
- Services and supplies for any illness or injury occurring on or after the *covered individual's effective date of coverage* as a result of war or an act of war.
- Services for, or in connection with, an intentional self-inflicted injury or illness while sane or insane, except when due to domestic violence or a medical (including both physical and mental) health condition.
- Services and supplies received from either a *covered individual's* or *covered individual's* spouse's relative, any individual who ordinarily resides in the *covered individual's* home or any such similar person.
- Services for, or in connection with, an injury or illness arising out of the participation in, or in consequence of having participated in, a riot, insurrection or civil disturbance or the commission of a felony.
- Charges for services for inpatient/outpatient hospitalization.
- Services or supplies for oral hygiene or plaque control programs.
- Services or supplies to correct harmful habits.

**APPENDIX C
DENTAL PLAN SPECIFICATIONS**

CONTRACT NUMBER: 2001

BENEFIT YEAR: January 1st through December 31st.

DENTAL BENEFITS BOOKLET REISSUANCE DATE: January 1, 2020

NEWBORN INFANTS:

Coverage is provided under this Group Dental Plan for congenital defects in newly born children of Covered Individuals.

DEDUCTIBLE:

IF TREATMENT IS RECEIVED FROM A DELTA DENTAL PPO DENTIST, procedures listed in the Schedule of Dental Benefits for which a Deductible applies are subject to a \$25.00 Deductible per Covered Individual per Calendar Year, not to exceed \$75.00 per family unit per Calendar Year.*

IF TREATMENT IS RECEIVED FROM A DELTA DENTAL PREMIER DENTIST, procedures listed in the Schedule of Dental Benefits for which a Deductible applies are subject to a \$50.00 Deductible per Covered Individual per Calendar Year, not to exceed \$150.00 per family unit per Calendar Year.*

IF TREATMENT IS RECEIVED FROM AN OUT-OF-NETWORK DENTIST, procedures listed in the Schedule of Dental Benefits for which a Deductible applies are subject to a \$50.00 Deductible per Covered Individual per Calendar Year.*

* In the event that some services are provided by a Delta Dental PPO or Delta Dental Premier Dentist and others by an out-of-network Dentist, the deductible is applied as follows:

1. The maximum combined deductible for benefits are subject to a \$50.00 Deductible per Covered Individual per Calendar Year..
2. Should a Covered Individual or Family Unit satisfy the deductible that applies to services provided by a Delta Dental PPO Dentist of Plan and subsequent services are provided by a Delta Dental Premier or Non-Delta Dentist, the Covered Individual or Family Unit shall be subject to the balance of the deductible that applies to services provided by a Delta Dental Premier or Non-Delta Dentist.

To satisfy this deductible amount, a Covered Individual or a Family Unit must incur within a Calendar Year this deductible amount.

The amount a Covered Individual pays for covered Dental Benefits for which the Deductible does not apply shall not be applied toward satisfying the deductible amount to other Dental Benefits otherwise covered under this Group Dental Plan.

COVERAGE LIMITS:

IF TREATMENT IS RENDERED BY A DELTA DENTAL PPO OR DELTA DENTAL PREMIER DENTIST, the maximum coverage limit (excluding orthodontic benefits) per Covered Individual per Benefit Period is \$2000.00.*

IF TREATMENT IS RENDERED BY AN OUT-OF-NETWORK DENTIST, the maximum coverage limit (excluding orthodontic benefits) per Covered Individual per Benefit Period is \$1200.00.*

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

1. The combined services cannot exceed the maximum coverage limit (excluding orthodontic benefits) of \$2000.00 per Covered Individual per Benefit Period.
2. Once an individual has exhausted \$1200.00 of benefits, the remaining \$800.00 must be for treatment with a Delta Dental PPO or Delta Dental Premier Dentist.

PLAN II:**COVERAGE LIMITS - ORTHODONTIA:**

IF TREATMENT IS RENDERED BY A DELTA DENTAL PPO OR DELTA DENTAL PREMIER DENTIST, lifetime orthodontic benefits payable by Delta Dental per dependent child under age 19 shall not exceed \$2000.00. Delta Dental will pay 50 percent of the submitted fee, not to exceed the \$2000.00 lifetime maximum per dependent child under age 19.

IF TREATMENT IS RENDERED BY AN OUT-OF-NETWORK DENTIST, lifetime orthodontic benefits payable by Delta Dental per dependent child under age 19 shall not exceed \$1000.00. Delta Dental will pay 50 percent of the submitted fee, not to exceed the \$1000.00 lifetime maximum per dependent child under age 19.

ENHANCED BENEFITS PROGRAM:

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

Those eligible for the Enhanced Benefits Program include the following:

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

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



Smart plans for smart mouths.

Delta Dental of Illinois
111 Shuman Boulevard
Naperville, IL 60563
800-323-1743

deltadentalil.com