Dental Benefits Summary
Delta Dental PPO plus Premier

Yale Graduate & Professional Student Dental Plan

Group # 04255

Topics Covered in This Booklet

Please note: The definitions for the words that appear in italics in the following pages can be found in the Glossary. In the event there appears to be any difference between the benefits described in this booklet and those provided in the group contract, the group contract shall prevail.

About This Brochure

This brochure contains a general description of your dental care program for your use as a convenient reference. All benefits are governed by the provisions of your group's contract with Delta Dental of Connecticut, Inc. This is not a summary plan description designed to meet the requirements of ERISA.

About Delta Dental

Delta Dental of Connecticut, Inc and Delta Dental of New Jersey, Inc. cover more than one million people in commercial, school board, and government programs. It is our mission to promote oral health to the greatest number of people by providing accessible dental benefits programs of the highest quality, service, and value.

Delta Dental is a member of the Delta Dental Plans Association, a national system of not-for-profit dental service corporations covering 54 million people across the country. The national Delta Dental system is the oldest and largest dental benefits system in the country and has led the industry in offering innovative programs designed to control costs while ensuring quality of benefits.

Delta Dental of Connecticut, Inc. writes dental coverage on an insured basis and Delta Dental of New Jersey, Inc. administers the benefit programs.

How to Use Your Program

Before visiting the *dentist*, check to see whether your *dentist* participates with Delta Dental in your program (e.g., *Delta Dental PPO plus Premier).*

At the time of your first appointment, tell your *dentist* that you are covered under this Delta Dental program. Give him or her your group's name and group number, as well as your Subscriber's ID number. Your dependents, if covered, also must give your number.

After your *dentist* performs an examination, he or she may submit a *Pre-Treatment Estimate* of benefits to Delta Dental to determine how much of the charge for any future work will be your responsibility.

Before treatment is started, be sure you discuss with your *dentist* the total amount of his or her fee. Although *Pre-Treatment Estimates* are not required, Delta Dental strongly recommends you ask your *dentist* to submit a *Pre-Treatment Estimate* for treatment costing $300 or more. This is especially important when using a *non-participating dentist* because the *Pre-Treatment Estimate* lets you know in advance how much of the costs are your responsibility. Please keep in mind that *Pre-Treatment Estimates* are only estimates and not a guarantee of payment.

Locating a *Dentist*
Delta Dental offers two easy ways to locate a *participating dentist* **24 hours a day, 7 days a week**. Subscribers can either:

- Call 1-800-DELTA-OK (1-800-335-8265)
- Search the Internet at www.deltadentalct.com

By calling the toll-free number, you can obtain a customized list of *participating dentists* within the geographic area of your request. Delta Dental mails the list to your home.

By searching on the Internet, you can obtain a list of *participating dentists* in a specific town. The list can be downloaded immediately, and you can search for as many towns as needed.

Using either method, you can request a list of Delta Dental *participating dentists* within a designated area. You can specify listings of *general dentists* only or specialists only. *Participating dentist* information can be obtained for *dentists* nationwide.

Why Select a *Participating Dentist*?
All Delta Dental *participating dentists* have agreed, in writing, to abide by our claims processing procedures. Through their commitment and support, we, in turn, can provide you with a program that's tailored to meet your dental health wants and needs.

- *Participating dentists* have agreed to accept the least of their actual charge, their prefiled fee, or Delta Dental's maximum allowable fee for the program as payment in full and to not charge patients for amounts in excess of those indicated in the "patient payment" portion of the *Explanation of Benefits*.
- *Participating dentists* will usually maintain a supply of *claim forms* (also referred to as Attending Dentist's Statements) in their office. You may be asked to complete a portion of the form when you visit.
- *Participating dentists* will complete the rest of the form, including a description of the services that were performed or will be performed in the case of a *Pre-Treatment Estimate*, and require that you sign the *claim form* in the appropriate place. For *dentists* who submit claims electronically to Delta Dental, you will need to authorize your *dentist* to maintain your signature on file.
- *Participating dentists* will mail, fax, or electronically submit the *claim form*, together with the appropriate diagnostic materials, directly to our offices for processing.
- *Participating dentists* agree to abide by Delta Dental processing policies. For example, *participating dentists* agree not to bill separate charges for infection control measures. *Non-participating* dentists are not bound by such policies.
- *Participating dentists* will, in the case of dental services which have been completed, receive payment directly from Delta Dental for that portion of the *treatment plan* which is covered by your dental program. You will receive an *Explanation of Benefits* with a detailed description of covered benefits and the amount of your obligation.
- If you visit a *non-participating dentist*, you will be responsible for payment. Delta Dental will reimburse you for the portion of your services covered by your program.

We advise that you check with your *dentist* to confirm whether he or she participates in the Delta Dental program under which you are covered. While a *dentist* may participate with Delta Dental, he or she may not participate in all of our programs.

Where Do I Call/E-mail?

Question	Phone Number	E-mail Address
Customer Service	800-452-9310	service@deltadentalnj.com
Obtain *claim forms*	800-452-9310	service@deltadentalnj.com
Explanation of Benefits	800-452-9310	service@deltadentalnj.com
Status of a claim	800-452-9310	service@deltadentalnj.com
Eligibility information	800-452-9310	service@deltadentalnj.com
Benefits information	800-452-9310	service@deltadentalnj.com
Completing the *claim form*	800-452-9310	service@deltadentalnj.com
Participating dentist list	800-DELTA-OK 800-335-8265	www.deltadentalct.com

Please note that all calls to our toll-free number first go through our *Interactive Voice Response* (*IVR*) system. Information available on the *IVR* includes eligibility, benefits, remaining maximum, *deductible*, claim payments, and ordering *claim forms*. Your question may be answered quicker by the *IVR*, where there is never a wait. You can also use this system to speak with a Customer Service agent. Note: A touch-tone phone is required.

We offer the following services for our non-English speaking and hearing-impaired subscribers:

Language Line Helper - a non-English speaking subscriber can also use our toll-free number. When the call is received, a translator will be obtained for the language the caller is fluent in and a three-way conversation will be held among the caller, translator, and a Delta Dental customer service agent.

TDD Line - a hearing-impaired member can call 1-800-246-1020 Monday through Thursday, 8:00 a.m. – 6:30 p.m. and Friday 8:00 a.m. – 5:00 p.m. and be connected with a TDD machine to also access our Customer Service agents.

If You Have Coverage Through Another Plan--*Coordination of Benefits*

Generally, if you are covered by more than one group dental plan and in some cases a group medical plan, your expenses will be shared between the plans, up to the full amount of the allowable charges. This includes dual Delta Dental coverage, as well as coverage by Delta Dental and another group plan.

Make sure you inform your *dentist* that you are covered by more than one plan. If you are covered by more than one Delta Dental of New Jersey plan, you just need to submit the claim once, and we will coordinate your benefits. If you are covered by Delta Dental and another group plan, you need to submit the claim to the primary group plan first. After the primary group plan has issued a statement of benefits, you need to send that statement of benefits to the second group plan along with a *claim form*.

Some groups coordinate benefits according to the *birthday rule* and some groups coordinate benefits according to the *gender rule*. Please see the Eligibility section to determine which rule your group follows for coordination of benefits.

By coordinating benefits, we avoid duplication of payment for the same services, managing your benefits dollars for future procedures and ensuring your group that we are effectively administering your benefits.

DELTA DENTAL OF CONNECTICUT (Delta Dental)
BENEFIT DETERMINATION AND APPEAL PROCESS SUMMARY

Predetermination of Benefits: This group dental plan **does not require** prior approval of dental services. Nonetheless, a Covered Individual and his/her treating Dentist may request a predetermination of benefits to obtain advance information on the plan's possible coverage of services before they are rendered. Payment, however, is limited to the benefits that are covered under this plan as of the date service is rendered and is subject to any applicable deductible, waiting periods, annual and lifetime coverage limits as well as this plan's payment policies.

Notice of Adverse Benefit Determination: If a claim is denied in whole or in part, Delta Dental shall notify the Subscriber and the treating Dentist of the denial in writing, by issuing an Explanation of Benefits (sometimes referred to as an Adverse Benefit Determination), within 30 days after the claim is filed, unless special circumstances require an extension of time, not exceeding 15 days, for processing. If an extension is necessary, Delta Dental shall notify the Subscriber and the Dentist of the extension and the reason it is necessary within the original 30-day period. If an extension is taken because either the Subscriber or the Dentist did not submit information necessary to decide the claim, the notice of extension shall specifically describe the required information and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Explanation of Benefits Form: This form includes the following information:

- The processing policy or policies (numerical code(s)) stating the specific reason(s) why the claim was denied, including a reference to specific plan provisions on which the denial is based; whether a specific rule, guideline or protocol was relied upon in making the Adverse Benefit Determination and if so, that a copy will be provided free of charge upon request; and a description of any additional information needed in order to perfect the claim as well as the reason why such information is necessary
- Reference in the processing policy or policies to the relevant scientific or clinical judgment, if the Adverse Benefit Determination is related to dental necessity, experimental treatment or other similar exclusion or limitation
- A description of Delta Dental's claim informal appeal and formal appeal processes and the time limits applicable to the processes.

Request for Informal Review

If the Subscriber or the billing Dentist disagrees with Delta Dental's Adverse Benefit Determination, either may within sixty (60) days of the mailing date of the Adverse Benefit Determination deliver a request to Delta Dental for informal review of the Adverse Benefit Determination. The procedure is explained on the reverse side of the Explanation of Benefits form. Delta Dental will issue its decision on the Informal Review within 60 days after receipt of the Informal Appeal. Subscribers are not required to request informal review. Any appeal relating to the original decision or the Informal Appeals decision must be made within 240 days following the mailing date of the original Adverse Benefit Decision.

Request for Appeal of Adverse Benefit Determination: If the Subscriber disagrees with Delta Dental's adverse Benefit Determination, he/she may appeal this determination to Delta Dental within 240 days following the mailing date of the original Adverse Benefit Determination. The appeal must be in writing and must state why it is believed that Delta Dental's benefit decision was incorrect. The denial notice, as well as any other documents or information bearing on the claim, should accompany the appeal request. Delta Dental's review of the claim upon appeal will take into account all comments, documents, records or other information submitted by the claimant, regardless of whether such information was submitted or considered in the initial benefit determination.

Delta Dental's Review: The review shall be conducted by a person who is neither the individual who made the initial claim denial nor the subordinate of such individual. If the review is of an Adverse Benefit Determination based in whole or in part on a determination related to dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the person who made the initial claim denial nor the subordinate of such individual. Delta Dental shall provide upon request of the claimant the name of any dental consultant whose advice was obtained in connection with the claim denial, whether or not that advice was relied upon in making the initial benefit determination.

Notice of Review Decision: Delta Dental shall notify the claimant in writing of its decision on the Formal Appeal within 30 days of its receipt of the appeal, unless it determines that special circumstances require an extension of time for processing as detailed below. In such cases, written notice of the extension shall be furnished to the claimant prior to the end of the initial 30-day period. In no event shall such extension exceed a period of 60 days from the end of the initial 30-day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which Delta Dental expects to render the determination on the appeal.

If Delta Dental upholds the Adverse Benefit Determination on appeal, the notice to the claimant shall include the following information:

- The processing policy or policies (numerical code(s)) stating the specific reason(s) for the adverse determination, with reference to specific plan provisions upon which the determination is based, whether a specific rule, guideline or protocol relied upon in making the determination, and if so, that a copy will be provided free of charge upon request.
- Reference in the processing policy or policies to the relevant scientific or clinical judgment, if the Adverse Benefit Determination is related to dental necessity, experimental treatment or other similar exclusion or limitation
- A statement that reasonable access to and copies of all documents, records and other information relevant to the denied claim are available free of charge upon request
- Advice that options for further recourse or for obtaining information may include contacting the state regulatory agency or local U.S. Department of Labor office.

**For the full version of the appeals process, please contact Delta Dental.

Health Care Fraud

It is insurance fraud to submit false information to a plan in order to obtain a larger payment than you are entitled to receive. False claims include submitting a claim for a service not actually rendered, misdescribing a service which was rendered, misrepresenting the amount of the fee the *dentist* charged and intended to collect (including failing to disclose that the *dentist* will waive all or part of the patient's copayment), or using an incorrect date for the actual rendering of the dental service.

Insurance fraud hurts everyone because it reduces the funds available to pay **bona fide** claims and can result in the termination of benefit plans due to increased costs. It has severe criminal and civil consequences to those who participate in the preparation or submission of such claims. We urge all plan participants to refrain from submitting or participating in the submission of false claims and to contact us at 973-285-4167 if you suspect that a false claim has been submitted.

Frequently Asked Questions

- Do I need to have an assigned *dentist*?

  No, this plan allows you to be treated by any licensed *dentist* of your choice. Generally, the least out-of-pocket expense can be achieved by using a *dentist* who participates with your specific plan type (e.g.: *Delta Dental PPO plus Premier*).

- Do I need a referral to a specialist?

  You are not required to have a referral to a specialist if you or your dependents require specialized care. Generally, you will maximize your benefits by utilizing the services of a specialist who participates with Delta Dental.

- Is it required to have a *Pre-Treatment Estimate* (pre-determination of benefits)?

  No, it is not required by Delta Dental that you obtain a *Pre-Treatment Estimate* of benefits prior to treatment. If your *dentist* indicates the need for treatment with dental charges in excess of $300, it is strongly recommended that you request an estimate of dental benefits before receiving the treatment. Both you and your *dentist* will receive a voucher from Delta Dental showing the estimated payable benefit. It will also indicate your estimated patient responsibility including *deductible* if applicable. Your *dentist* needs to complete this voucher and submit it for payment when work has been completed. *Pre-Treatment Estimate*s are only estimates and not a guarantee of payment. Payments of the approved services are subject to eligibility and to contract limitations (e.g., annual maximums) at the time services are rendered.

- Do I need an ID card as proof of coverage when I visit a *dentist*?

  If your University has issued an identification card, you should show it to your *dentist*. However, it is not required that a *dentist* see an ID card before rendering treatment. An ID card does not verify active coverage. You or your *dentist* may obtain your group number, current eligibility and benefit information by contacting Delta Dental at (800) 452-9310 24 hours a day, 7 days a week or by accessing Delta Dental's on-line Benefit's Connection tool at www.deltadentalct.com.

- What if I have questions about my benefits?

  You can call our Customer Service Department at (800) 452-9310 and speak to a representative between 8:00 a.m. and 6:30 p.m. EST Monday-Thursday and between 8:00 a.m. and 5:00 p.m. EST Friday. Also, our *interactive voice response* system can provide benefit, eligibility, remaining maximum and *deductible* information, and history of your recent claims 24 hours a day, 7 days a week along with Delta Dental's on-line Benefit Connection tool.

- How do I file a claim for dental charges?

  There are several easy ways to submit a claim. Your *dentist* can complete a Delta Dental *claim form* or an ADA (American Dental Association) approved form and mail it to: Delta Dental of New Jersey, P.O. Box 16354, Little Rock, AR 72231. The *claim form* may also be faxed to 1-800-324-7939. If your *dentist* files claims electronically through his or her computer, no *claim form* is required. This method also speeds processing time.

  Also, you may download a claim form from our web site and submit the claim as well.

  Each individual patient must have his or her own claim filed separately from another family member's claim. Also, each different *dentist* visited must submit a separate claim. However, an individual *dentist* may submit a claim for payment and a *Pre-Treatment Estimate* on the same *claim form*.

- What must the claim form contain?

  The claim must contain the treating dentist's signature and either the covered person's signature or a representation from the treating dentist that the covered person has signed a written authorization for the dentist to submit the claim. The claim must also name the patient, the specified date of service and fee charged, and request approval for payment of a specific treatment, service or product.

- When will Delta Dental communicate its benefit determination?

  Delta Dental will notify you of its benefit determination for urgent care claims as soon as possible but not later than 72 hours after receipt of the claim, providing sufficient information was received. If the claim is not complete, then Delta Dental will notify you or your representative within 48 hours after receipt of the claim.

  Delta Dental will notify you of its benefit determination for post-service claims within a reasonable period of time, but not later than 30 days after receipt of the claim. If Delta Dental needs to extend their decision another 15 days, they will notify you of the reason for the extension and estimated determination date prior the initial 30-day period.

- What will Delta Dental do if there is an adverse benefit determination?

  If the benefit determination is adverse, Delta Dental will notify you in writing. The notice will specify the reason(s), refer to the specific plan provision, guideline or protocol upon which the determination was based, describe any additional material or information needed for you to complete the claim and explain why such documentation is necessary, and describe the initial appeal process and time limits. In addition, if the adverse determination was based on medical necessity or exclusion for experimental treatment, the notification will either provide an explanation or offer to provide one free of charge upon request.

- Is there a time limit for submitting dental claims?

  Yes, in most cases, you have one full year from the date of service to submit your dental claims. If there is coordination of benefits involved and Delta Dental is not the primary carrier, you have one year from the date on which the primary carrier(s) issues a statement of benefits. If the claim is submitted after these time frames, then the services are not covered.

- What can I do if I am dissatisfied with the initial adverse benefit determination?

  You can file a request for informal review within 60 days of the adverse determination. You would send it to:

  Delta Dental of New Jersey, Inc.
  Attn: Appeals Department
  P.O. Box 15132
  Little Rock, AR 72231

  Your request must include the claim number, name and address of the member, name of the University, date of service and description of service, your signature and date of signature, date you received Delta Dental's adverse determination, reason(s) why you think the determination was incorrect and any relevant documents and information.

  The person making the decision at Delta Dental will be a person who did not make the initial determination and who is not the subordinate of the initial reviewer. The decision-maker for a determination based in whole or in part on medical judgment will consult with a health care professional who has training and experience involved in medical judgment and who was not consulted in the earlier determination(s).

  Delta Dental will notify you in writing of its determination within 72 hours for urgent care claims and within 30 days for pre-service claims. If the benefit determination is adverse, the notice will specify the reason(s), refer to the specific plan provision, guide or protocol upon which the determination was based, inform you of your right to receive free of charge, upon request, all relevant documentation, and describe any voluntary, external appeal procedures as well as your right to bring civil (court) action. In addition, if the adverse determination was based on medical necessity or exclusion for experimental treatment, the notification will either provide an explanation or offer to provide one free of charge upon request.

- What can I do if I am dissatisfied with the informal appeal decision?

  You or your dentist must request a formal review in writing within 240 days of receipt of the original adverse benefit determination (whether or not you requested an informal review) and send it to:

  Delta Dental of New Jersey, Inc.
  Attn: Correspondence Department
  P.O. Box 15132
  Little Rock, AR 72231

  The request for a formal review must include the dentist's name, office name, address and license number, the subscriber's name, subscriber's ID number and date of birth, the patient's name, date of birth, the claim number, the reason(s) why Delta Dental should change its initial decision and the specific decision you are seeking, any relevant information or diagnostic materials, and/or a copy of the claim for the determination you are appealing. You must also sign the request. If the dentist is authorized to act on your behalf he/she must state that and include a proper authorization form. Delta Dental will notify you in writing of its determination within 72 hours for urgent care claims, and within 30 days for pre- and post-service claims.

- How do eligible children attending college away from home find a *participating dentist*?

  A customized list of *participating dentists* for a specific geographic location can be obtained by calling 1-800-DELTA-OK or 1-800-335-8265. This list will be mailed or can be faxed in case of an emergency situation. Also, listings of *participating dentists* throughout the country are available on our web site at www.deltadentalct.com.

- How is my plan maximum calculated?

  Your *maximum benefits* payable are either based on a *contract year* or a coverage period (determined by your University group). All procedures that are paid by Delta Dental will be applied to your plan maximum. If your contract provides benefits for orthodontia or other specific benefits such as TMJ coverage, they may have their own separate annual or lifetime limits. In addition, you may have an individual annual maximum or a combined family maximum for everyone under your coverage.

- If I am not located in the same state as my University's headquarters, where do I call?

  No matter where you are located in the country, you can still call the same toll-free number (800-452-9310) to reach our Customer Service Department, Monday to Thursday, 8 a.m. to 6:30 p.m. EST. and Friday 8:00 a.m. to 5:00 p.m. EST. Our *Interactive Voice Response* system is available 24 hours a day, 7 days a week.

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

  The *alternative benefit* provision of your group contract is applied when there are two dentally acceptable ways to treat a dental condition and both procedures are covered. In such cases your benefit is based on the treatment that costs less. This does not mean that your *dentist* made a poor recommendation. In fact, you may use Delta Dental's payment towards the treatment you choose. Since Delta Dental's payment is the same no matter which treatment you choose, you may have higher out-of-pocket expenses if you choose the treatment that costs more.

- For more Frequently Asked Question please visit Delta Dental's web site at www.deltadentalct.com.

Description of Covered Services

See following page for program descriptions

	Delta Dental PPO plus Premier			
	00001 (Base Plan) If a Delta Dental PPO℠ Dentist or Participating Specialist is used	**00001 (Base Plan)** If a Delta Dental Premier® or Non Participating Dentist is used	**01001 (Enhanced Plan)** If a Delta Dental PPO℠ Dentist or Participating Specialist is used	**01001 (Enhanced Plan)** If a Delta Dental Premier® or Non Participating Dentist is used
Preventive & Diagnostic Services (No Deductible)	100%	100%	100%	100%
▪ Exams, Cleanings, (each twice per contract year per person, ages 14 and older are considered adults) ▪ X-rays-full mouth series or panoramic (either one, once in five years) ▪ X-rays-bitewing (twice per contract year per person under 19 and once per contract year per person 19 and older) ▪ X-rays-single films (multiple x-rays on the same date of service will not exceed the benefit of a full-mouth series) ▪ Fluoride Treatment (twice per contract year coverage period, for eligible children to age 19, combinations with cleanings are applied to time limits for both) ▪ Space Maintainers (once per space for missing posterior primary teeth, for children under age 14) ▪ Consultations are counted as exams for purposes of frequency limitations				
Remaining Basic (After Deductible)	80%	50%	80%	50%
▪ Fillings - composite and amalgam. Payment is allowed for one restoration per tooth surface in 365 days ▪ Simple Extractions				
Remaining Basic (After Deductible)	Not Covered	Not Covered	50%	50%
▪ Oral Surgery (impacted wisdom teeth claims should first go to medical carrier) ▪ Endodontics (root canals on permanent teeth once per lifetime per tooth) ▪ Periodontics (have specific frequency limitations, pre-treatment estimate is strongly recommended - e.g. surgery once per 36 months)				
Remaining Basic (After Deductible)	Not Covered	Not Covered	80%	80%
▪ Sealants (1st and 2nd permanent, decay-free molars, once in a lifetime per tooth, for children to age 16)				
Prosthodontics & Crowns (After Deductible for High Plan Major Services only)	Not Covered	Not Covered	50%	50%
▪ Crowns and crown-related procedures (post and core, core buildup, etc., once every ten years, permanent teeth only, for ages 12 and older) ▪ Bridgework (once every ten years, for ages 16 and older) (bridges with four or more missing teeth in that arch may be given an alternate benefit of a partial denture) ▪ Full & Partial Dentures (either one, once every ten years, partial dentures for ages 16 and older) (fixed bridges and removable partial dentures are not benefits in the same arch; benefits will be provided for the removable partial denture only) ▪ Repair of Dentures (Repair of existing prosthetic appliances) ▪ Inlays (inlays are only payable when done in conjunction with an onlay; by themselves they are given the alternate benefit of an composite filling)				

	Delta Dental PPO plus Premier			
	00001 (Base Plan) If a Delta Dental PPO℠ Dentist or Participating Specialist is used	**00001 (Base Plan)** If a Delta Dental Premier® or Non Participating Dentist is used	**01001 (Enhanced Plan)** If a Delta Dental PPO℠ Dentist or Participating Specialist is used	**01001 (Enhanced Plan)** If a Delta Dental Premier® or Non Participating Dentist is used
Contract Year Maximum (per person)	$1,000.00	$500.00	$1,500.00	$1,000.00
Contract Year Deductible				
▪ Individual	*$50.00	*$50.00	**$50.00	**$50.00
▪ Family (family deductible is accumulated by individual deductibles)	*$100.00	*$100.00	**$100.00	**$100.00

* Deductible applies to Basic services only
**Separate annual deductible applies to Basic, Crowns and Major services

Description of Programs

Delta Dental PPO plus Premier - See Explanation under "Product Descriptions" section at back of booklet.

Non-participating dentists may balance bill above the maximum allowable charge.

Eligibility Requirements

Your plan begins when the following requirements have been satisfied:

- All new subscribers and their dependents will be covered from the group coverage period commencement date of October 1st.

- An eligible subscriber is a student enrolled and registered at least half time as of the fall term in a Yale University graduate or professional school degree program (G&P students) and who is not eligible for coverage under the Yale University Student Dental Plan or as a Yale COBRA participant shall be eligible to purchase dental coverage for a full 12- month period, with coverage effective October 1. Coverage must be purchased for the full 12- month period. Those G&P students that meet the eligibility criteria but choose not to purchase dental coverage until after the annual enrollment period has passed must wait until the next annual enrollment period to purchase coverage.

Eligible Dependents

- Your spouse

- Dependent children (subject to age limitations).

    - Children include step-children, adopted children, and foster children, provided such children are dependent upon the subscriber for support and maintenance.
    - Children from 2 to age 19.
    - Your legally adopted child (including a child for whom legal adoption proceedings have already been started).
    - Handicapped children - in order for mentally or physically handicapped children to remain covered, you must show proof of the child's incapacity. This proof must be attached to the first claim submitted to Delta Dental.

When does coverage terminate?

Coverage for subscribers and their eligible dependents shall cease upon the earliest of:

- Termination of group contract
- Termination of the contract year

Coverage for a dependent child shall terminate upon attaining the limiting contract age (see eligibility section).

Exclusions and Limitations: Services Not Covered by This Dental Plan

- To be eligible for coverage, a service must be required for the prevention, diagnosis, or treatment of a dental disease, injury, or condition. Services not dentally necessary are not covered benefits. Your dental plan is designed to assist you in maintaining dental health. The fact that a procedure is prescribed by your dentist does not make it dentally necessary or eligible under this program. We can request proof (such as x-rays, pathology reports, or study models) to determine whether services are necessary. Failure to provide this proof may cause adjustment or denial of any procedure performed.
- Services for injuries or conditions which are compensable under Workers Compensation Universitys Liability Laws; services provided to the eligible patient by any Federal or State Government Agency or provided without cost to the eligible patient by any municipality, county, or other political subdivision.
- Services with respect to congenital or developmental malformations (including TMJ and replacing congenitally missing teeth), cosmetic surgery, and dentistry for purely cosmetic reasons (e.g., bleaching, veneers, or crowns to improve appearance).
- Services provided in order to alter occlusion (change the bite); replace tooth structure lost by wear, abrasion, attrition, abfraction, or erosion; splint teeth; or treat or diagnose jaw joint and muscle problems (TMJ).
- Specialized or personalized services (e.g., overdentures and root canals associated with overdentures, gold foils) are excluded and a benefit will be allowed for a conventional procedure (e.g., benefiting a conventional denture towards the cost of an overdenture and the root canals associated with it. The patient is responsible for additional costs.)
- Prescribed drugs, analgesics (pain relievers), fluoride gel rinses, and preparations for home use.
- Procedures to achieve minor tooth movement.
- Experimental procedures, materials, and techniques and procedures not meeting generally accepted standards of care.
- Educational services such as nutritional or tobacco counseling for the control and prevention of oral disease. Oral hygiene instruction or any equipment or supplies required.
- Services rendered by anyone who does not qualify as a fully licensed *dentist*.
- Charges for hospitalization including hospital visits or broken appointments, office visits, and house calls.
- Services performed prior to effective date or after termination of coverage. Benefits are payable based on date of completion of treatment.
- Services performed for diagnosis such as laboratory tests, caries tests, bacterial studies, diagnostic casts, or photographs.
- Temporary procedures and appliances, pulp caps, occlusal adjustments, inhalation of nitrous oxide, analgesia, local anesthetic, and behavior management.
- Procedures or preparations which are part of or included in the final restoration (bases, acid etch, or micro abrasion).
- Transplants, implants, and procedures directly associated with implants including crowns and bridgework and their restoration and their maintenance or repair.
- Periodontal charting, chemical irrigation, delivery of local chemotherapeutic substances, application of desensitizing medicine, synthetic bone grafts, and guided tissue regeneration.
- Post removal (not in conjunction with root canal therapy).

- Completion of claim forms, providing documentation, requests for pre-determination, and services submitted for payment more than twelve (12) months following completion.
- Separate fee for infection control and OSHA compliance.
- Maxillofacial surgery and prosthetic appliances.
- Remaining Basic
- Crowns, Inlays and Gold Restorations
- Prosthodontics
- Orthodontics

This is a general description of your dental plan to be used as a convenient reference, and some exclusions and limitations may not be listed. All benefits are governed by your group contract.

"IMPORTANT: If you opt to receive dental services or procedures that are not covered benefits under this plan, a participating dental provider may charge you his or her usual and customary rate for such services or procedures. Prior to providing you with dental services or procedures that are not covered benefits, the dental provider should provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your evidence of coverage document."

Glossary

Term	Definition
Alternate Benefit	A provision in a dental plan contract that allows the third-party payer to determine the benefit based on an alternative procedure that is generally less expensive than the one provided or proposed. Patient financial liability is dependent upon the treatment chosen.
Amalgam	A silver material used to fill cavities that is placed on the tooth surface that is used for chewing because it is a particularly durable material.
Birthday Rule	Coordination-of-benefits regulation stipulating that the primary payer of benefits for dependent children is determined by the parents' birth dates. Regardless of which parent is older, the dental benefits program of the parent whose birthday falls first in a contract year is considered primary.
Bitewing	A dental x-ray showing approximately the coronal (crown) halves of the upper and lower jaw.
Claim Form	The paper form the dentist must file for reimbursement for services rendered.
COB	Coordination of Benefits. A method of integrating benefits payable under more than one plan.
COBRA	Consolidated Omnibus Budget Reconciliation Act. A law that requires certain Universitys to offer continued health insurance coverage to eligible students and/or their dependents who have had their health insurance coverage terminated.
Completion Date	The date a procedure is completed. It is the insertion date for dentures and partial dentures. It is the cementation date (regardless of the type of cement used) for inlays, onlays, crowns, and fixed bridges.
Composite	White resin material used to fill cavities. It is used primarily because the color more closely resembles the natural tooth than does the color of amalgam.
Consultation	A discussion between the patient and the dentist where the dentist offers professional advice for the proposed treatment plan.
Contract Year	A period of one year beginning with the effective date of the group contract.

Covered Family Members	You and your spouse and dependent children who are covered under this program.
Deductible	The amount of dental expense your group requires you to pay before Delta Dental assumes any liability for payment of benefits. Deductible may be an annual or one-time charge, and may vary in amount from program to program.
Delta Dental PPO*SM*	Delta Dental's basic preferred provider option (PPO).
Delta Dental Premier®	Delta Dental's traditional fee-for-service dental benefits program.
Dentist	A person licensed to practice dentistry by the appropriate authority in the area where the dental service is given.
Endodontist	A dentist who specializes in diseases of the tooth pulp, performing such services as root canals.
General Dentist	A dentist who provides a full range of dental services for the entire family.
IVR	Interactive Voice Response system. Information can be accessed by touch-tone telephone 24 hours a day on: eligibility, benefits, claim information, and ordering claim forms.
Maximum Benefit	The maximum dollar amount a program will pay toward the cost of dental care incurred by an individual or family in a specified period, usually a calendar year.
NMAC	Non-Participating Dentist Maximum Amount Used for Benefit Calculation or is the highest fee as determined by Delta Dental for purposes of calculating the payment amount for services performed by *non-participating dentists*.
Non-Participating Dentist	A state-licensed dentist who does not have a written participation agreement with Delta Dental.
Notification of Delta Dental Benefits	A statement that explains how your claim was processed, payment by Delta Dental, your responsibility, and other pertinent information. Also referred to as an EOB (Explanation of Benefits) or Notification of Payment (NOP).
Oral Pathologist	A dentist who is concerned with recognition, diagnosis, and management of the diseases of the mouth, jaws, and surrounding structures.

Oral Surgeon	A dentist who removes teeth, including impacted wisdom teeth, repairs fractures of the jaw and performs surgery on the mouth, jaws, and surrounding structures.
Orthodontist	A dentist who corrects misaligned teeth and jaws, usually by applying braces.
Participating Dentist	A state-licensed dentist who has a written agreement with a Delta Dental Plan to perform services and receive payment under this program.
Participating Specialist	A participating dentist with Delta Dental of New Jersey who holds a specialty permit in endodontics, periodontics, prosthodontics, oral surgery, or orthodontics; limits his/her practice to that specialty; and has registered with Delta Dental as a specialist.
Pediatric Dentist	A dentist who generally limits his/her practice to children and teenagers and the handicapped. Also known as Pedodontist.
Periodontist	A dentist who treats diseases of the gums.
PMAC	The Participating Dentist Maximum Approved Charge is the highest fee as determined by Delta Dental for purpose of compensating *participating dentists* for services.
PSMAC	The Participating Specialist Maximum Approved Charge is the highest fee as determined by Delta Dental for purpose of compensating *participating specialist* for services.
Pre-Treatment Estimate	Pre-authorized estimate of services detailing payment of allowable benefits.
Prophylaxis	Prevention of disease by removal of calculus, stains, and other extraneous materials from the teeth. The cleaning of the teeth by a dentist or dental hygienist.
Prosthodontist	A dentist who generally specializes in ways to replace missing natural teeth with bridges and dentures.
Treatment Plan	A written report prepared by a dentist showing the dentist's recommended treatment of any dental disease, defect, or injury.

Product Descriptions

Delta Dental PPO[SM] plus Premier[®]

When you receive Covered Services from a Delta Dental PPO[SM] Dentist, the Dentist has agreed to accept the least of the actual charge for the service, the filed fee, or the fee in the Delta Dental PPO[SM] Schedule applicable to the Master Group Contract as payment in full. You will be responsible for the coinsurance percent that corresponds to the Covered Service. Using a Delta Dental PPO[SM] Dentist will mean lower cost to you.

For specialist services, when you receive Covered Services from a Delta Dental Participating Specialist, the Dentist has agreed to accept the least of the actual charge for the service, the filed fee, or the Participating Specialist Maximum Allowable Charge (PSMAC) established by Delta Dental as payment in full. You will be responsible for the coinsurance percent that corresponds to the Covered Service.

You may also choose to receive Covered Services from a Delta Dental (Premier[®]) Participating Dentist who is not a Delta Dental PPO[SM] Dentist. The Delta Dental (Premier[®]) Participating Dentist has agreed to accept the least of the actual charge for the service, the filed fee, or the Participating Dentist Maximum Allowable Charge (PMAC) established by Delta Dental as payment in full. If you receive Covered Services from a Delta Dental (Premier®) Participating Dentist, Delta Dental's payment is based on the PMAC. You will be responsible for the coinsurance percent that corresponds to the Covered Service.

If you choose to receive services from a Non-Participating Dentist, Delta Dental's benefit payment may be based on the least of the Dentist's actual charge or the Non-Participating Dentist Maximum Allowable Charge (NMAC). You will pay the difference between the amount paid by Delta Dental and the full amount charged by the Non-Participating Dentist.

You can generally save on your out-of-pocket costs by receiving Covered Services from a Delta Dental Participating Dentist. A Delta Dental (Premier®) Participating Dentist helps reduce your financial responsibility by limiting fees to the PMAC. But, your out-of-pocket costs will be even lower when you receive Covered Services from a Delta Dental PPO[SM] Dentist whose fees are limited to the contracted Delta Dental PPO[SM] Schedule.

Your benefit levels may vary based on the program in which your Dentist participates as indicated in the Description of Covered Services which appears in this Booklet.

You are responsible for payment of the applicable Deductible and the difference between Delta Dental's payment and the fee approved by Delta Dental.

NOTES:

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