



PLAN DEFINITIONS

Scheduled Benefit Plan is a voluntary dental insurance plan that is available to groups of at least 2 enrolled employees (Five enrolled employees are required in OR and WA). Rates are determined based on the size of the group either 2-9 lives or 10+ lives. If a group applies for the 10+ rates but has less than 10 lives upon enrollment, the rates will be adjusted accordingly. This plan allows for employees to utilize the dental provider of their choice.

Coverage is provided for only the procedures listed in the coverage schedule, and the scheduled dollar amount represents the maximum benefit to be paid, not to exceed actual charges.

There are three coverage levels available with the Scheduled Benefit Plan – Gold, Silver and Bronze. The Gold and Silver Plans cover a wide range of procedures, including Diagnostic, Preventative, Restorative, Endodontics, Periodontics and Prosthetics. The Gold Plan also includes Orthodontics. The Bronze plan is a low cost value plan that covers basic diagnostic, preventative and restorative items, plus two oral procedures. **The Bronze plan can be sold alone or as part of a dual choice option.**

Dual Choice Option - Employers may choose to offer the Bronze plan to their employees as a dual choice option with any of the other Dental Indemnity USA plans, including the R&C plans. The employee would then have the choice of which of the two plans he would like to participate in.

Reasonable and Customary Benefit Plan is a voluntary dental insurance plan that is available to groups of at least 30 enrolled employees. This plan allows for employees to utilize the dental provider of their choice. Coverage is provided for only the procedures listed in the coverage schedule, and payment will be based on the stated benefit percentage applied to the lesser of: 1.) dental provider's actual charges; or 2.) the maximum allowable charge for the procedure.

ELIGIBILITY

Q. Are there participation requirements?

A. For the Scheduled Indemnity Benefit Plan, the minimum participation is 2 or more enrolled employees. For the Reasonable and Customary Dental Benefit Plan, the minimum participation is 30 enrolled employees.

Q. Are there any industries that would be excluded from coverage?

A. No, there are no ineligible industries.

Q. How many hours must an employee work in order to be eligible for coverage?

A. Coverage is offered to full-time employees working 20 or more hours per week.

Q. Are dependent children covered?

A. Yes, dependent children are covered to age 19, to age 25 for full-time students. Handicapped dependents are eligible as long as they were incapacitated before the age limit was reached. There is no age limit for coverage on handicapped dependents. Supportive documentation on handicapped status may be requested.

Q. Are domestic partners covered?

A. The Company will follow the definition of domestic partner as defined in the local city or county ordinance, where the policyholder is located. If applicable, an affidavit, along with the employee enrollment applications, will be required attesting to the items. All documents must be submitted with the enrollment materials. The Insurance Certificate will be amended to reflect the definition of dependents as being expanded to include domestic partners that have completed an affidavit. Benefits will be effective on the first of the month following the signing of the documents, depending on what the contract has for spouse eligibility.



ELIGIBILITY continued

Q. Can an employee enroll at any time throughout the year?

A. An employee can only enroll at the time of eligibility or during the policyholder's scheduled annual enrollment period.

Q. If a qualifying event occurs, can an employee add a spouse and/or children during the year and if so, what are the requirements?

A. An employee can add coverage only if there has been a qualifying event. Examples of a qualifying event include: marriage, birth/adoption of a child, divorce, change in insurance status etc. Each individual will have his or her own probationary period. Additionally, the employer will have final determination so as not to disrupt the benefit and payroll deduction process. Many employers only allow changes during annual enrollment periods, except under specific guidelines. If there is not a qualifying event, the employee must wait until the next annual enrollment period.

Q. What if the employee was previously covered under a spouse's plan and benefits are no longer available to the employee?

A. The employee and/or spouse can enroll because this is a qualifying event. However, the 12-month probationary period for services will still apply.

Q. To which services does the probationary period apply?

A. The 12-month probationary period applies to the following benefits: Major Restorative, Periodontics, Prosthetics and Orthodontic, which is only available with the selection of the Gold Plan. The Bronze plan has no probationary period.

Q. Are probationary periods waived for the treatment of accidental injuries?

A. Probationary periods will not be waived for the treatment of accidental injuries.

TAKEOVER BENEFITS

Q. Do the rates include continuity of coverage?

A. While both dental plans allow for continuity of coverage, there are separate, higher takeover rates if this option is desired.

Q. If an employer selects takeover rates, is continuity of coverage included?

A. Continuity of coverage would be included. All Insureds covered under the prior plan will not be subject to a probationary period for Major Restorative, Periodontics, Prosthetics and Orthodontics if the prior plan covered such services. If the prior plan did not cover procedures and services in these categories, Insureds must satisfy the probationary period. New enrollees and new employees must still satisfy the probationary period. Replacement rates do not apply to the Bronze plan because procedures that effect replacement are not included in the plan.

Q. What materials does a broker need to submit with a takeover case?

A. The following must be submitted with a takeover case: Application for Group Voluntary Dental Benefits, Employee Enrollment forms, a copy of the prior carrier's certificate booklet or policy and the last month's billing statement indicating covered employees and their level of coverage (single/family).

Q. Will the probationary period for employees who transfer plans mid-year be waived?

A. All Insureds covered under the prior plan will not be subject to a probationary period for Major Restorative, Periodontics, Prosthetics and Orthodontics if the prior plan covered such services. If the prior plan did not cover procedures and services in these categories, Insureds must satisfy the probationary period.



TAKEOVER BENEFITS continued

- Q. If an employer had orthodontic coverage on the prior plan and is selecting a Gold Plan in either the Scheduled Benefit Plan or Reasonable and Customary Dental Plan, how will those benefits be handled during a takeover?**
- A. Takeover benefits, if purchased, apply to orthodontics only if the employer's prior plan also included ortho coverage. In applying takeover to ortho treatment in progress, remaining benefits will be determined by subtracting benefits previously paid for ortho from this plan's ortho maximum.

ADMINISTRATION

- Q. When should initial enrollment be held?**
- A. The initial enrollment period should be held at least 45 days prior to the effective date of coverage.
- Q. When do sold case materials need to be submitted?**
- A. The sold case materials need to be submitted at least 30 days prior to the effective date of coverage. This is to insure that the employees and employer receive their materials in a timely manner and individuals are entered into the system prior to the effective date of coverage. This is important in order to verify coverage.
- Q. What materials does a broker need to submit for a standard case?**
- A. The broker needs to submit the following: Application for Group Voluntary Dental Benefits, Enrollment forms for each employee to be covered and a binder check for the first month's premium made payable to either Fort Dearborn Life Insurance Company or Medical Life Insurance Company.
- Q. Can a group have an effective date other than the first of the month?**
- A. Effective dates will always be the first of the month. A group cannot have an effective date other than the first of the month.
- Q. Can a group submit premium through a wire transfer?**
- A. Yes, a wire transfer is an acceptable method of payment and should be set-up through DNOA's finance department.
- Q. How are terminations handled for billing purposes?**
- A. Terminations will always be handled on the last day of the month. Groups can submit terminations by using the individual enrollment form or by submitting a request on company letterhead via mail or fax.
- Q. How long are rates guaranteed?**
- A. Rates are guaranteed for a period of twelve (12) months beginning on the group's effective date
- Q. What is the procedure to obtain a 5500 form?**
- A. The filing of 5500 forms are not required for voluntary dental.
- Q. Can the voluntary dental premium be offered on a pre-tax basis under a Section 125 Plan?**
- A. The voluntary dental premium can be offered on a pre-tax basis under a Section 125 Plan, unless specific state regulations do not permit it.



GROUP / MEMBER ISSUANCE

Q. What does the employer and insured receive once a case has been sold?

- A. The employer receives the following: Welcome letter, Certificate of Insurance, ID cards, claim form, key contact list, plan brochure, coverage schedules and enrollment form. New groups are typically processed within 21 days of receipt of new case materials.

The new members receive the following: Certificate of Insurance, ID card, claim form, plan brochure and applicable coverage schedule. The employer will deliver these items to the insured.

Q. What is the contact phone number if members have questions about their program?

- A. A Customer Service Department is available to answer employer and employee questions between the hours of 8:00am – 6:00pm., Central Standard Time, Monday through Friday. The toll-free telephone number is 1-800-820-9994.

BENEFITS

Q. What is the annual deductible?

- A. Both the Scheduled Benefit Plan and the Reasonable and Customary Dental Plan have an annual deductible of \$50 per person per calendar year, \$150 per family per calendar year, exclusive of preventive and diagnostic services.

Q. What is the annual maximum per calendar year?

- A. The annual maximum per calendar year is \$1000 per each covered individual.

Q. What is the maximum for orthodontic coverage?

- A. Orthodontic coverage, available only on the Gold Plan, has a \$1000 lifetime maximum for dependent children under the age of 19 for orthodontic services after the probationary period has been completed. 50% of reasonable and customary covered orthodontic diagnostic procedures and treatment costs will be covered, up to the \$1000 lifetime maximum allowance.

Q. What constitutes a calendar year?

- A. A calendar year is defined as a year beginning January 1 through December 31. If a group signs on December 1, the group would receive the full deductible and full annual maximum benefit for one month and then the process would start over on January 1.

Q. Is orthodontic coverage available under both plans?

- A. Orthodontic coverage is available under the Scheduled Benefit Plan and the Reasonable and Customary Benefit Plan, but only with the selection of the Gold Plan option. 50% of the covered orthodontic diagnostic procedures and treatment costs will be covered, up to the \$1000 lifetime maximum allowance.

Q. How many dental cleanings and exams are allowed each calendar year?

- A. A member may receive benefits for two dental cleanings and exams per calendar year.



BENEFITS continued

Q. If an employer has more than one location and has selected the Scheduled Benefit Plan, which ZIP code would be used to determine the applicable region and coverage schedule?

A. There are two options for determining the correct region and coverage schedule for an employer with two locations.

The first option would base the region and coverage schedule by the employer's main address and the group would only receive one bill. The ZIP code of the employer's main address would determine the region for the entire group, regardless of the other locations' ZIP codes.

The second option would require that each location have a minimum of 2 enrolled employees at each location. This option would utilize separate bills for each location and the coverage schedule would be determined by the ZIP code of the employer's main address for each separate location. This option would require separate billing for each location. Combined billed groups will have a separate account number for each location.

Q. If an employee works in one region but lives in another, which coverage schedule would apply for that individual?

A. A coverage schedule based on the employer's location is applicable for the entire group, regardless of an individual's location.

Q. Is this product portable?

A. No, this coverage is not portable.

Q. Can a group upgrade from the Silver Plan to the Gold Plan on either of the plans offered?

A. A group can upgrade to the Gold Plan on the group's next anniversary date.

Q. Can dental benefits be continued under COBRA?

A. Dental benefits can be continued under COBRA provided the employer assumes responsibility for COBRA compliance. COBRA eligible participants will appear on the statement along with other covered employees. Those participants can be sub-grouped for tracking purposes. Federal COBRA applies to groups with 20 or more employees (on more than 50% of its typical business days in the previous calendar year). For employers with fewer than 20 employees, state coverage continuation laws may apply. Those employers need to consult applicable state continuation laws for more details.

Q. What happens if an employee is disabled, takes a leave of absence, is laid-off or goes on strike?

A. The employer determines eligibility as per the contract. As long as the premiums are paid, the employee's coverage will be continued.

Q. Is either of the plans offered on a network basis?

A. Neither of the voluntary plans is networked based. An employee may choose any dental provider. (May vary in some states)

CLAIMS

Q. From what location are claims processed?

A. Claims are processed for Fort Dearborn Life and Medical Life by Dental Network of America at P.O. 23060, Belleville, IL 62223-0060.

Q. What is the average turnaround time for a submitted paper claim?

A. Currently, 94% of all claims transactions, regardless of the scope of the claim, are completely processed within 14 days of receipt. One hundred percent of the outstanding claims are processed within 30 days of receipt.



CLAIMS continued

Q. How are claims administered?

A. The dental provider files a standard claim form and payment is made either directly to the provider or the insured. Claims are processed within 14 business days.

Q. Is there an appeals process for denied claims?

A. If a claim is denied, the provider and/or the insured are notified of the disposition of the claim. The provider or the insured may file an appeal. The appeal will be submitted to DNoA's Benefit Policy Committee. The committee members would make a determination and notify the provider and the insured of the Committee's decision.

Q. Does the dental product coordinate with other benefits?

A. Dental claims are coordinated with other benefits. If an insured is covered by more than one dental plan, then the primary carrier is determined. The contracted member always retains his or her own insurance as primary. If he or she has additional coverage through a spouse, that insurance is considered secondary. When a dependent child has dual coverage, the parent with the earlier birthday in the calendar year provides the primary benefit for the child.

Q. How does coordination of benefits work?

A. Coordination of benefits (COB) works the same for all procedures including orthodontics, if applicable. DNoA will request a copy of the primary carrier's EOB. DNoA will then calculate the normal benefit that the plan will pay. This amount is the amount that DnoA will pay, as long as the combined payments do not exceed the provider's charges or the annual/lifetime maximum. If the combined payments exceed the provider charges or the annual lifetime maximum, the payment will be adjusted.

Q. What is considered the official start of orthodontia treatment?

A. Orthodontia treatment is considered to have started on the date the appliance or bands are inserted or on the date a one-step orthodontic procedure is performed. Orthodontia treatment is only a covered benefit on the Gold Plan. There is a 12-month probationary period for orthodontic coverage. If appliances or bands are placed prior to the insured being eligible, no benefits will be paid.

Q. Can the initial consultation for orthodontia treatment be prior to the actual 12-month probationary period?

A. The initial consultation for orthodontia treatment can be prior to the completion of the 12-month probationary period, but that visit will not be a covered benefit.

Q. How is the payment method for orthodontia claims determined?

A. Quarterly payments are made based on the total cost of treatment and the expected time of treatment. For example: a \$1000 case over 24 months would be paid as \$125 per quarter over the 24 months of treatment. This payment can be made either to the provider or the insured.

Q. Will DNoA honor claims for services rendered outside the U.S.?

A. DNoA will honor claims for services rendered outside the country. Usually the member will pay the provider and submit a bill to DNoA for reimbursement. It is helpful if the charges and procedures performed are translated prior to submitting to DNoA for reimbursement. DNoA can adjust the payment based on the exchange rate, if necessary.

Q. Does either voluntary dental plan require or allow a pretreatment estimate?

A. These plans do not require pretreatment estimates. However, insured members are encouraged to have a pretreatment estimate anytime services over \$200 are being considered or if there is a question regarding benefits and coverage.



CLAIMS continued

- Q. Do either the Scheduled Benefit Plan or the Reasonable and Customary Benefit Plan provide coverage for TMJ procedures?**
- A. The coverage schedule provided with the certificate of insurance lists the accepted dental procedures. Many of the ADA codes and procedures associated with TMJ are not included in either plan. Please review the full list of codes and procedures to determine if a particular service or treatment is covered under the selected plan. (May vary in some states)
- Q. What claims history information can a customer service representative access in real time in response to an inquiry on processed and pending claims?**
- A. DNoA's customer service representatives have online real time access to all claims processed, including the ability to reference all claims history, status and a complete visual tooth chart for each covered individual.
- Q. Can a covered individual replace a full or partial denture, bridge, inlay or crown?**
- A. Once the probationary period has passed, members can replace prosthetics if the original is five or more years old.