



DENTAL HEALTH PLAN



ou and your eligible family members have the opportunity to enroll in the Boston University Dental Health Plan. You and the University share the cost of your coverage under the Dental Health Plan. The Dental Health Plan is designed to provide you with high-quality care at an affordable price. There are two different plans from which to choose:

(1) The BU Dental Health Center Plan or (2) The Dental Blue Freedom Plan.

Eligibility

If you are classified by the University as a regular employee, work 50% or more of a full-time schedule, and have an appointment of nine months' or more duration, you and your eligible family members may participate in the Boston University Dental Health Plan starting on the first day of the month coincident with or following your first day of work.

Your eligible family members include:

- Your legally married spouse
- Your children under age 26
- Your unmarried, dependent children age 26 and older who are mentally or physically handicapped

Employees whose percentage time worked decreases below the eligibility requirements for the Boston University Dental Health Plan as of January 1, 2015, will no longer be able to participate in the Boston University Dental Health Plan (subject to COBRA).

Coverage Levels

There are four levels of coverage available under the Dental Health Plan:

- Individual coverage (yourself only)
- Individual plus spouse (you and your spouse)
- Individual plus child(ren) (you and one or more of your children)
- Family coverage (you and your eligible family members)

Dependent Eligibility Documentation Required

For all eligible dependents whom you wish to cover under the BU plan, you must provide the following documents:

- Spouse: Marriage certificate (government issued)
- Common Law Spouse: Common law marriage certificate (only for those married in a state that accepts common law marriage)
- Child: Birth certificate or adoption certificate or certificate of live birth
- Stepchild: Birth certificate of child plus marriage certificate of current spouse (stepchild is eligible only if one of their birth parents is also covered as a spouse on the family coverage)
- Ward: Court ordered document of legal custody

Special Provisions for Former Spouses

If you have family coverage including your spouse and you divorce, your spouse may continue to be covered under your family coverage:

- If the divorce order specifically calls for this, and
- If neither you nor your former spouse remarries.

If you or your former spouse remarries, your former spouse's eligibility for coverage ends. Once coverage ends, your former spouse may continue coverage on an individual basis under COBRA for the remaining period (if any) until 36 months have gone by since your divorce or separation.

Special Tax Considerations

Under current tax laws, the value of your former spouse's dental coverage is subject to federal income and Social Security taxes. These taxable amounts are based on the full amount of an individual plan (that is, employee contribution plus employer contribution) and are called imputed income. Imputed income for your former spouse's dental coverage will be reported as income on each paycheck, and will be included in the taxable earnings shown on your W-2 Form. Coverage for your former spouse is subject to imputed income for tax purposes.

Enrollment

Participation in the Boston University Dental Health Plan is voluntary. To elect this coverage, new employees must go to Employee Self Service at www.bu.edu/buworkscentral. This process will also authorize a payroll deduction to pay for your share of the cost.

If you choose a coverage level that includes your spouse or dependent children, coverage is available only for the family members who are listed on your enrollment. If you wish to enroll newly eligible family members (for example, an adopted child or a new spouse), please notify Human Resources at hr@bu.edu for details on making a change to your benefits.

When Coverage Starts

You have 30 days following your benefit orientation date to enroll. If you enroll, coverage will become effective on the first day of the month coincident with or following your first day of work. If you do not enroll during this period, your next opportunity to enroll will be during the next open enrollment period.

Cost

You and the University share the cost of your coverage under the Dental Health Plan. Currently, the University pays a portion of the coverage cost as determined by the University. Your share of the cost is the difference between the total cost of coverage and the amount that Boston University pays. Costs are subject to change at the beginning of each plan year. Also, the University may change the percentage of the cost that it will pay.

How Dental Health Plan Contributions Are Paid

You pay for your portion of the contributions for your Dental Health Plan coverage with pre-tax dollars. This is because Boston University automatically reduces your pay by the amount of your payments—before federal income taxes, state income taxes, and Social Security taxes are taken out.

Automatic before-tax premium payments are allowed under the provisions of Section 125 of the Internal Revenue Code. These are explained in more detail in the “Flexible Benefits” section of this handbook.

Changing or Stopping Coverage

Because you pay for your coverage with before-tax dollars, the provisions of Section 125 of the Internal

Revenue Code also govern how and when you may make changes in your Dental Health Plan coverage. Under the current provisions of Section 125, you may

- Change the level of your coverage (that is, move from individual to family coverage or vice versa), or
- Cancel your coverage once each year, during the annual open enrollment period.

The only other time you may make a change in your Dental Health Plan coverage is if you have an IRS-approved Qualifying Life Event in your family or employment status. Qualified Changes are explained in the “Flexible Benefits Program and Flexible Spending Accounts” section of this handbook.

About the Boston University Dental Health Centers

There are two Boston University Dental Health Centers. Both provide a comprehensive range of dental services, such as X-rays, cleanings, fillings, and crowns.

You will be examined by a licensed staff dentist when you receive your care at one of the Dental Health Centers. Preventive services such as cleanings and X-rays will be provided by licensed dental hygienists.

If you require any specialty services such as orthodontics (braces), oral surgery (extractions), endodontics (root canals), or periodontics (gum surgery), both centers can refer you to the appropriate licensed specialist and/or postdoctoral resident found within either Center.

Your care will be monitored by your staff dentist at one of the Dental Health Centers. The standard fees-for-service provided through the

Dental Health Centers are already far below those charged by most private practices. Therefore, the Dental Health Centers offer you and your family members a unique opportunity to obtain quality dental care at a reasonable price.

The Boston University Dental Health Centers are conveniently located at:

- 930 Commonwealth Avenue near the Charles River Campus
Phone: 617-358-1000
- 635 Albany Street at the Boston University Medical Center
Phone: 617-358-8300

The BU Dental Health Center Plan

How the Plan Works

If you join this plan, you must receive your dental treatment from one of the BU Dental Health Centers located at 930 Commonwealth Avenue and 100 East Newton Street. There is no coverage for care received outside of the Centers (except for emergency dental treatment at a participating BCBS Dental Blue provider).

Covered Services

The Boston University Dental Health Center Plan covers services listed on the following chart.

Here are two special features of the plan that you should remember:

- There are no deductibles for covered services.
- You do not have to complete claim forms for services provided at the Dental Health Centers.

Boston University Dental Health Center Plan Covered Services	
Type of Service	Boston University Dental Health Center Dentists*
Preventive & Diagnostic	100%
Basic Restorative	100%
Major Restorative	60%
Orthodontia	50%
Annual Maximum Benefit**	\$1,700 per person, per year
Orthodontia Lifetime Maximum Benefit	\$2,000 per person, lifetime

*The percentage of the cost of a covered service that is paid by the plan is based on the standard fee schedule established by the Boston University Dental Health Centers. You may obtain a copy of the standard fee schedule by contacting Human Resources at HR@bu.edu or online at www.bu.edu/hr/documents/BN_enrollment_form.pdf.

**Maximum applies to claims paid for any BCBS dental plan in the same calendar year.

Preventive and Diagnostic

Diagnostic Services

- One complete initial oral exam, including initial dental history and charting of the teeth and supporting structures
- Single-tooth X-rays as needed
- Bitewing X-rays of the crowns of the teeth (once each six months)
- Full-mouth X-rays (seven or more films, or panoramic X-ray with bitewing X-rays; once each 60 months)
- Study models and casts used in planning treatment (once each 60 months)
- Emergency exams
- Periodic or routine oral exams (once each six months)

Preventive Services

- Routine cleaning, scaling, and polishing of the teeth (once each six months)
 - Fluoride treatment for members under age 19 (once each six months)
- Space maintainers required due to premature loss of teeth for

members under age 19

- Sealants applied to permanent premolar and molar surfaces for members under age 14 (one application each 48 months for each premolar or molar surface)

Basic Restorative Services

- Amalgam (silver) fillings (limited to one filling for each tooth surface in each 12 months). No benefits are provided for fillings on tooth surfaces where a sealant was applied within the last 12 months.
- Composite resin (tooth color) fillings on front teeth (limited to one filling for each tooth surface in each 12 months). These benefits include single-surface composite resin fillings on back teeth.
- Pin retention for fillings
- Stainless steel crowns on primary (baby) teeth
- Stainless steel crowns on first permanent (adult) molars for members under age 16

Prosthetic Maintenance

- Repair of partial or complete dentures, crowns, and bridges (once each 12 months)
- Adding teeth to an existing partial or complete denture
- Rebase or relin dentures (once each 36 months)
- Recementing of crowns, inlays, onlays, and fixed bridgework (once each 12 months)

Other Covered Services

- Occlusal adjustments (once each 24 months)
- Services to treat root sensitivity
- General anesthesia when administered in conjunction with covered surgical services

- Emergency dental treatment to relieve acute pain

Major Restorative Services

Oral Surgery

- Tooth extractions
- Root removal
- Biopsies

Periodontics (Gum and Bone)

- Periodontal scaling and root planing (once in each quadrant each 24 months)
- Periodontal surgery (soft and hard tissue surgeries; once in each quadrant each 36 months)
- Periodontal maintenance following active periodontal therapy (once each three months)

Endodontics (Root and Pulp)

- Root canal therapy on permanent teeth (once in a lifetime for each tooth)
- Retreatment root canal therapy on permanent teeth (once in a lifetime for each tooth)
- Therapeutic pulpotomy on primary or permanent teeth for members under age 16
- Other endodontic surgery intended to treat or remove the dental root

Prosthodontics (Tooth Replacement)

- Complete or partial dentures, including services to fabricate, measure, fit, and adjust them (once each 60 months for each arch)
- Fixed bridges, including services to fabricate, measure, fit, and adjust them (once each 60 months for each tooth)
- Replacement of dentures and bridges, but only when they are installed at least 60 months after the initial placement, and

only if the existing appliance cannot be made serviceable

- Temporary partial dentures to replace any of the six upper or lower front teeth, but only if they are installed immediately following the loss of teeth and during the period of healing

Crowns, Inlays, and Onlays

- Crowns for members age 16 or older (once each 60 months for each tooth). **Note:** These benefits include single-tooth dental endosteal implants (the fixture and abutment portion) when the implant replaces permanent teeth through the second molars (once each 60 months for each tooth).
- Metallic, porcelain, and composite resin inlays for members age 16 or older
- Metallic, porcelain, and composite resin onlays for members age 16 or older (once each 60 months for each tooth)
- Replacement of crowns for members age 16 or older (once each 60 months for each tooth)
- Replacement of metallic, porcelain, and composite resin onlays (once each 60 months for each tooth)
- Replacement of metallic, porcelain, and composite resin onlays for members age 16 or older (once each 60 months for each tooth)
- Post and core or crown buildup for members age 16 or older (once each 60 months for each tooth)

Orthodontics

Orthodontic benefits, including braces and related services during treatment, are provided for

adults and children when care is provided by a dentist located at a Boston University Dental Health Center.

Emergency Care

The plan defines “emergency treatment” as treatment needed to immediately alleviate pain or infection or to treat an injury.

Emergency treatment is covered as a basic restorative service, regardless of where it is provided. Emergency treatment does not include any final restorations (i.e., root canal, crowns, and dentures).

Non-Covered Dental Services

No benefits are provided by the Boston University Dental Health Center Plan for:

- Services, supplies, procedures, or appliances to treat an illness or injury for which you have the right to benefits under government programs. These include the Veterans Administration for an illness or injury connected to military service. They also include programs set up by other local, state, federal, or foreign laws or regulations that provide or pay for health care services and supplies or that require care or treatment to be furnished in a public facility. No benefits are provided if you could have received governmental benefits by applying for them on time. This exclusion does not include Medicaid or Medicare.
- Charges that are received for or related to dental care that Blue Cross Blue Shield considers to be experimental. The care must be documented by controlled studies that determine its merits (such as its safety) and include sufficient follow-up studies.

- Charges for appointments that you do not keep. Dentists may charge you for failing to keep your scheduled appointments. They may do so if you do not give reasonable notice to the office. Appointments that you do not keep are not counted against any benefit limits described in this BU Dental Health Center Plan benefit description.
- A service, supply, procedure, or appliance that is not described as a covered dental service in this BU Dental Health Center Plan benefit description
- Services, supplies, procedures, or appliances that do not conform to Blue Cross Blue Shield dental policy guidelines
- Any service or supply furnished along with, in preparation for, or as a result of a non-covered dental service
- Services, supplies, procedures, and appliances that are not considered necessary and appropriate by Blue Cross Blue Shield
- Services, supplies, procedures, and appliances that are furnished to someone other than the patient
- Treatment and related services that are required by third parties
- Free care or care for which you are not required to pay or for which you would not be required to pay if you were not covered under the BU Dental Health Center Plan
- Nutrition counseling or instructions in dental hygiene, including proper methods of tooth brushing, the use of dental floss, plaque control programs, and caries (cavity) susceptibility tests
- Incomplete procedures
- Laboratory or bacteriological tests

- Consultations when the dentist who renders the consultation provides treatment
- Restorations for reasons other than decay or fracture of teeth, such as erosion, abrasion, or attrition
- Sealants applied to permanent premolar or molar surfaces that have decay or fillings
- Fillings on tooth surfaces where a sealant was applied within the last 12 months
- Replacement of a filling within 12 months of the date of the prior restoration
- Stainless steel crowns on permanent (adult) teeth, other than on first permanent (adult) molars for members under age 16
- Fixed or removable prosthodontics or major restorative procedures for members under age 16 (The BU Dental Health Center Plan provides the benefit for a temporary partial denture for replacement of a lost or missing tooth. You pay any balance.)
- Temporary complete dentures or temporary fixed bridges
- Replacement of dentures, bridges, or space maintainers for reasons such as theft, abuse, misuse, misplacement, loss, improper fit, allergies, breakage, or ingestion
- Duplicate dentures or bridges
- Transplants or any related surgical or restorative procedures
- Any procedure to save a tooth when there is a poor statistical probability (less than a 70% chance) that the tooth will last for 60 months (for example, surgical periodontal regenerative procedures to stabilize a tooth

loosened due to extensive periodontal disease)

- Cast restorations, copings, or attachments for installing overdentures, including associated endodontic procedures such as root canals
- Precision attachments, semiprecision attachments, or copings
- A service to diagnose or treat temporomandibular joint (TMJ) disorders or myofascial (muscular) pain, including bruxism (grinding of the teeth). This service is covered under the Blue Cross Blue Shield medical policies.
- A service, supply, or procedure when its sole purpose is to increase the height of teeth (vertical dimension) or to restore occlusion
- A separate charge for occlusal analysis, pulp vitality testing, or pulp capping since these services are usually performed as part of another covered procedure
- Drugs, pharmaceuticals, biologicals, or other prescription agents or products
- Photographs
- A dentist's charge to file a claim. Also, a dentist's charge to transcribe or copy your dental records
- Services and supplies furnished before your effective date, except for a multi-stage procedure that begins before your effective date and is completed while you are enrolled under the BU Dental Health Center Plan
- Services and supplies furnished after your termination date under the BU Dental Health Center Plan. (If your membership under

the BU Dental Health Center Plan is terminated prior to the completion date of a procedure that requires more than one visit, no benefits are provided for the entire procedure.)

How to Obtain Benefits

To obtain benefits for services provided at the Boston University Dental Health Centers, simply show your Blue Cross Blue Shield membership card. You do not have to complete a claim form for services provided at the Dental Health Centers.

The Dental Blue Freedom Plan

How the Plan Works

This is a unique dental plan, designed especially for BU employees who may not be able to conveniently receive all their dental care services at the BU Dental Health Centers. It provides you three choices of dental providers; you decide where to receive treatment each time you need dental care. You have access to providers at the BU Dental Health Centers; Blue Cross Blue Shield dental network providers; or you may choose your own provider. Plan benefits vary based on where you receive care.

Covered Services

The Dental Blue Freedom Plan covers services listed on the chart on the next page.

Preventive and Diagnostic

Diagnostic Services

- One complete initial oral exam, including initial dental history and charting of the teeth and supporting structures
- Single-tooth X-rays as needed

Dental Blue Freedom Plan Covered Services				
Service	Coverage at Centers*	BCBS Dental Blue & PPO (in Massachusetts) Networks**	Dental Blue (National) Network**	Out-of-Network Provider***
Deductible	None	\$50 per person	\$50 per person	\$50 per person
Preventive & Diagnostic	100%	80%, no deductible	80%, no deductible	80%, no deductible
Basic Restorative	80%	60%, after deductible	60%, after deductible	60%, after deductible
Major Restorative	50%	40%, after deductible	40%, after deductible	40%, after deductible
Orthodontics	50%	Not covered	Not covered	Not covered
Annual Maximum Benefit****	\$1,700 per person, per year			
Orthodontia Lifetime Maximum Benefit	\$2,000 per person, lifetime			

*Based on the BU Dental Health Center Table of Allowance

**Based on lesser of either the dentist's actual charge or the allowed charge. If your provider is in the Dental Blue PPO Network, your share of the cost of services may be less than if your provider is in only the Dental Blue Network. To determine which networks your provider participates in, review your provider's profile on the Blue Cross Blue Shield website at www.bluecrossma.com/findadoctor.

***Based on the actual charge or the allowed charge, whichever is less. The allowed charge is based on a schedule of charges. You may be responsible for any difference between the dentist's actual charge or the allowed charge, whichever is less.

****Maximum applies to claims paid for any BCBS dental plan in the same calendar year.

- Bitewing X-rays of the crowns of the teeth (once each six months)
- Full-mouth X-rays (seven or more films, or panoramic X-ray with bitewing X-rays; once each 60 months)
- Study models and casts used in planning treatment (once each 60 months)
- Emergency exams
- Periodic or routine oral exams (once each six months)

Preventive Services

- Routine cleaning, scaling, and polishing of the teeth (once each six months)
- Fluoride treatment for members under age 19 (once each six months)
- Space maintainers required due to premature loss of teeth for members under age 19
- Sealants applied to permanent premolar and molar surfaces for members under age 14 (one application each 48 months for each premolar or molar surface)

Basic Restorative Services

- Amalgam (silver) fillings (limited to one filling for each tooth surface in each 12 months). No

benefits are provided for fillings on tooth surfaces where a sealant was applied within the last 12 months

- Composite resin (tooth color) fillings on front teeth (limited to one filling for each tooth surface in each 12 months). These benefits include single-surface composite resin fillings on back teeth
- Pin retention for fillings
- Stainless steel crowns on primary (baby) teeth
- Stainless steel crowns on first permanent (adult) molars for members under age 16

Prosthetic Maintenance

- Repair of partial or complete dentures, crowns, and bridges (once each 12 months)
- Adding teeth to an existing partial or complete denture
- Rebase or relin dentures (once each 36 months)
- Recementing of crowns, inlays, onlays, and fixed bridgework (once each 12 months)

Other Covered Services

- Occlusal adjustments (once each 24 months)
- Services to treat root sensitivity

- General anesthesia when administered in conjunction with covered surgical services
- Emergency dental treatment to relieve acute pain

Major Restorative Services

Oral Surgery

- Tooth extractions
- Root removal
- Biopsies

Periodontics (Gum and Bone)

- Periodontal scaling and root planing (once in each quadrant each 24 months)
- Periodontal surgery (soft and hard tissue surgeries; once in each quadrant each 36 months)
- Periodontal maintenance following active periodontal therapy (once each three months)

Endodontics (Root and Pulp)

- Root canal therapy on permanent teeth (once in a lifetime for each tooth)
- Retreatment root canal therapy on permanent teeth (once in a lifetime for each tooth)
- Therapeutic pulpotomy on primary or permanent teeth for members under age 16

- Other endodontic surgery intended to treat or remove the dental root

Prosthodontics (Tooth Replacement)

- Complete or partial dentures, including services to fabricate, measure, fit, and adjust them (once each 60 months for each arch)
- Fixed bridges, including services to fabricate, measure, fit, and adjust them (once each 60 months for each tooth)
- Replacement of dentures and bridges, but only when they are installed at least 60 months after the initial placement, and only if the existing appliance cannot be made serviceable
- Temporary partial dentures to replace any of the six upper or lower front teeth, but only if they are installed immediately following the loss of teeth and during the period of healing

Crowns, Inlays, and Onlays

- Crowns for members age 16 or older (once each 60 months for each tooth) **Note:** These benefits include single-tooth dental endosteal implants (the fixture and abutment portion) when the implant replaces permanent teeth through the second molars (once each 60 months for each tooth).
- Metallic, porcelain, and composite resin inlays for members age 16 or older
- Metallic, porcelain, and composite resin onlays for members age 16 or older (once each 60 months for each tooth)
- Replacement of crowns for members age 16 or older (once each 60 months for each tooth)
- Replacement of metallic, porcelain, and composite resin inlays

(once each 60 months for each tooth)

- Replacement of metallic, porcelain, and composite resin onlays for members age 16 or older (once each 60 months for each tooth)
- Post and core or crown buildup for members age 16 or older (once each 60 months for each tooth)

Orthodontics

Orthodontic benefits, including braces and related services during treatment, are provided for adults and children when care is provided by a dentist located at a Boston University Dental Health Center.

Emergency Care

The plan defines “emergency treatment” as treatment needed to immediately alleviate pain or infection or to treat an injury. Emergency treatment is covered as a basic restorative service, regardless of where it is provided. Emergency treatment does not include any final restorations (i.e., root canal, crowns, and dentures).

Non-Covered Dental Services

No benefits are provided by the Dental Blue Freedom Plan for:

- Services, supplies, procedures, or appliances to treat an illness or injury for which you have the right to benefits under government programs. These include the Veterans Administration for an illness or injury connected to military service. They also include programs set up by other local, state, federal, or foreign laws or regulations that provide or pay for health care services and supplies or that require care or treatment to be

furnished in a public facility. No benefits are provided if you could have received governmental benefits by applying for them on time. This exclusion does not include Medicaid or Medicare.

- Charges that are received for or related to dental care that Blue Cross Blue Shield considers to be experimental. The care must be documented by controlled studies that determine its merits (such as its safety) and include sufficient follow-up studies.
- Charges for appointments that you do not keep. Dentists may charge you for failing to keep your scheduled appointments. They may do so if you do not give reasonable notice to the office. Appointments that you do not keep are not counted against any benefit limits described in this Dental Blue Freedom Plan benefit description.
- A service, supply, procedure, or appliance that is not described as a covered dental service in this Dental Blue Freedom Plan benefit description
- Services, supplies, procedures, or appliances that do not conform to Blue Cross Blue Shield dental policy guidelines
- Any service or supply furnished along with, in preparation for, or as a result of a non-covered dental service
- Services, supplies, procedures, and appliances that are not considered necessary and appropriate by Blue Cross Blue Shield
- Services, supplies, procedures, and appliances that are furnished to someone other than the patient
- Treatment and related services that are required by third parties

- Free care or care for which you are not required to pay or for which you would not be required to pay if you were not covered under the Dental Blue Freedom Plan
- Nutrition counseling or instructions in dental hygiene, including proper methods of tooth brushing, the use of dental floss, plaque control programs, and caries (cavity) susceptibility tests
- Incomplete procedures
- Laboratory or bacteriological tests
- Consultations when the dentist who renders the consultation provides treatment
- Restorations for reasons other than decay or fracture of teeth, such as erosion, abrasion, or attrition
- Sealants applied to permanent premolar or molar surfaces that have decay or fillings
- Fillings on tooth surfaces where a sealant was applied within the last 12 months
- Replacement of a filling within 12 months of the date of the prior restoration
- Stainless steel crowns on permanent (adult) teeth, other than on first permanent (adult) molars for members under age 16
- Fixed or removable prosthodontics or major restorative procedures for members under age 16. (The Dental Blue Freedom Plan provides the benefit for a temporary partial denture for replacement of a lost or missing tooth. You pay any balance.)
- Temporary complete dentures or temporary fixed bridges
- Replacement of dentures, bridges, or space maintainers for reasons such as theft, abuse, misuse, misplacement, loss, improper fit, allergies, breakage, or ingestion
- Duplicate dentures or bridges
- Transplants or any related surgical or restorative procedures
- Any procedure to save a tooth when there is a poor statistical probability (less than a 70% chance) that the tooth will last for 60 months (for example, surgical periodontal regenerative procedures to stabilize a tooth loosened due to extensive periodontal disease)
- Cast restorations, copings, or attachments for installing overdentures, including associated endodontic procedures such as root canals
- Precision attachments, semiprecision attachments, or copings
- A service to diagnose or treat temporomandibular joint (TMJ) disorders or myofascial (muscular) pain, including bruxism (grinding of the teeth). This service is covered under the Blue Cross Blue Shield medical policies.
- A service, supply, or procedure when its sole purpose is to increase the height of teeth (vertical dimension) or to restore occlusion
- A separate charge for occlusal analysis, pulp vitality testing, or pulp capping since these services are usually performed as part of another covered procedure
- Drugs, pharmaceuticals, biologicals, or other prescription agents or products
- Photographs
- A dentist's charge to file a claim. Also, a dentist's charge to transcribe or copy your dental records
- Services and supplies furnished before your effective date, except for a multi-stage procedure that begins before your effective date and is completed while you are enrolled under the Dental Blue Freedom Plan.
- Services and supplies furnished after your termination date under the Dental Blue Freedom Plan. (If your membership under the Dental Blue Freedom Plan is terminated prior to the completion date of a procedure that requires more than one visit, no benefits are provided for the entire procedure.)

Boston University Dental Health Centers

There are two Boston University Dental Health Centers. Both provide a comprehensive range of dental services, such as X-rays, cleanings, fillings, and crowns. Fees for dental services are found in your dental fee schedule.

Locations: 930 Commonwealth Avenue, Phone: 617-358-1000

and 635 Albany Street, Phone: 617-358-8300.

Key services include: general dentistry, dental hygiene, orthodontics, pediatric dentistry, periodontics, implantology, prosthodontics, oral and maxillofacial surgery, and endodontics.

In-Network Dentists

BCBS Network

Dental Blue PPO dentists provide you with the greatest value.

If your provider is in the Dental Blue

PPO Network, your share of the cost of services may be less than if your provider is in only the Dental Blue Network. To determine which networks your provider participates in, review your provider's profile on the Blue Cross Blue Shield website at www.bluecrossma.com/findadoctor.

How to Locate a Dentist on the Web

Go to the Blue Cross Blue Shield website at www.bluecrossma.com/findadoctor and look under "Dental Blue." If the dentist is in the BCBS Network, his or her name will be listed. You may also want to check to find out if the dentist is in the PPO Network. If he or she is, your coinsurance may be lower than for a dentist not in the PPO Network.

How Fees Are Set

This plan uses dentists in the Dental Blue Network.

You may use dentists in the Dental Blue or the Dental Blue PPO networks. All of these dentists are contracted with Blue Cross Blue Shield. If your dentist is in the PPO Network, your coinsurance may be lower than it would be for a dentist who is not in the PPO Network.

Out-of-Network Dentists

Benefits for covered services by a non-participating dentist outside of Massachusetts are provided based on usual and customary charges. The allowed charge is based on a schedule of charges established by BCBS. You may be responsible for any difference between the dentist's actual charge or the allowed charge, whichever is less. You are also responsible for your deductible and coinsurance (if applicable), and charges beyond your calendar-year maximum.

Out-of-network dentists do not have contracts with Blue Cross Blue Shield. Blue Cross Blue Shield will reimburse you the percentage listed on the chart of the usual and customary charges.

How to File a Claim

BU Dental Health Centers and BCBS Network Dentists

To obtain benefits for services provided at the BU Dental Health Centers or from a Blue Cross Blue Shield network dentist, show the dentist your Dental Blue Freedom identification card. The dentist will file the claim with Blue Cross Blue Shield. You do not have to file a claim form.

Out-of-Network Dentists

The following are procedures for obtaining benefits if your provider is not affiliated with a Boston University Dental Health Center and is not in the Blue Cross Blue Shield network:

1. Obtain a claim form from Human Resources or from the website at www.bu.edu/hr/forms-documents.
2. Pay your dentist for services.
3. Submit your claim form with original itemized bills within two years of the date you received the covered dental service to:

Blue Cross Blue Shield of
Massachusetts
P.O. Box 986030
Boston, MA 02298

Blue Cross Blue Shield will review your claim, then reimburse you for the claim to the extent of your benefits described in this handbook.

Appealing a Denial for Either Dental Health Plan

How to Request a Formal Grievance Review

To request a formal review from Blue Cross Blue Shield's Grievance Program, you (or your authorized representative) have three options.

The preferred option is for you to send your grievance in writing to:

Member Grievance Program
Blue Cross Blue Shield of
Massachusetts
One Enterprise Drive
Quincy, MA 02171-2126

Blue Cross Blue Shield will let you know that your request was received by sending you a written confirmation within 15 calendar days.

Or, you may email your grievance to Blue Cross Blue Shield's Grievance Program email address at grievances@bcbsma.com. Blue Cross Blue Shield will let you know that your request was received by sending you a confirmation immediately by email.

Or, you may call Blue Cross Blue Shield's Grievance Program at 1-800-462-5601 (extension 63605). When your request is made by telephone, Blue Cross Blue Shield will send you a written account of the grievance within 48 hours of your phone call.

Once your request is received, Blue Cross Blue Shield will research the case in detail, ask for more information as needed, and let you know in writing of the decision or the outcome of the review. If your grievance is regarding termination of coverage for concurrent services that were previously approved by Blue Cross Blue Shield, the disputed coverage will continue until this grievance review process is completed. This continuation of coverage does not

apply to services that are limited by dollar or visit maximums and that exceed those maximums, non-covered services, or services that were received prior to the time that you requested a formal grievance review, or when a grievance is not received on a timely basis, based on the course of treatment.

All grievances must be received by Blue Cross Blue Shield within one year of the date of treatment, event, or circumstance, such as the date you were told of the service denial or claim denial.

What to Include in a Grievance Review Request

Your request for a formal grievance review should include: the name and identification number of the member asking for the review; a description of the problem; all relevant dates; names of health care providers or administrative staff involved; and details of the attempt that has been made to resolve the problem. If Blue Cross Blue Shield needs to review the medical/dental records and treatment information that relate to your grievance, Blue Cross Blue Shield will promptly send you an authorization form to sign if needed. You must return this signed form to Blue Cross Blue Shield. It will allow for the release of your medical/dental records. You also have the right to look at and get copies (free of charge) of records and criteria that Blue Cross Blue Shield has and that are relevant to your grievance, including the identity of any experts who were consulted.

Authorized Representative

You may choose to have another person act on your behalf during the grievance review process. You must designate this person in writing to Blue Cross Blue Shield. Or, if

you are not able to do this, a person such as a conservator, a person with power of attorney, or a family member may be your authorized representative. Or, he or she may appoint another party to be the authorized representative. (When you are an inpatient, a health care provider may act as your authorized representative to ask for an expedited grievance review. You do not have to designate the health care provider in writing.)

Who Handles the Grievance Review

All grievances are reviewed by individuals who are knowledgeable about Blue Cross Blue Shield and the issues involved in the grievance. The individuals who will review your grievance will be those who did not participate in any of Blue Cross Blue Shield's prior decisions regarding the subject of your grievance, nor do they work for anyone who did. When a grievance is related to a necessity and appropriateness denial, at least one grievance reviewer is an individual who is an actively practicing health care professional in the same or similar specialty that usually treats the medical/dental condition, performs the procedure, or provides treatment that is the subject of your grievance.

Response Time

The review and response for Blue Cross Blue Shield's formal grievance review will be completed within 30 calendar days. Every reasonable effort will be made to speed up the review of grievances that involve health care services that are soon to be obtained by the member. (When the grievance review is for services you have already obtained and it requires a review of your medical/dental records, the 30-day response time will not include the days from

when Blue Cross Blue Shield sends you the authorization form to sign until it receives your signed authorization form if needed. If Blue Cross Blue Shield does not receive your authorization within 30 calendar days after you are asked for it, Blue Cross Blue Shield may make a final decision about your grievance without that medical/dental information.)

Note: If your grievance review began after an inquiry, the 30-day response time will begin on the day you tell Blue Cross Blue Shield that you disagree with Blue Cross Blue Shield's answer and would like a formal grievance review.

Blue Cross Blue Shield may extend the time frame to complete a grievance review, with your permission, in cases when Blue Cross Blue Shield and the member agree that additional time is required to fully investigate and respond to the grievance. A grievance that is not acted upon within the specified time frames will be considered resolved in favor of the member.

Written Response

Once the grievance review is completed, Blue Cross Blue Shield will let you know in writing of the decision or the outcome of the review. If Blue Cross Blue Shield continues to deny coverage for all or part of a health care service or supply, Blue Cross Blue Shield's response will explain the reasons. It will give you the specific medical and scientific reasons for the denial and a description of alternative treatment, health care services, and supplies that would be covered.

Grievance Records

Blue Cross Blue Shield will maintain a record of all formal grievances, including the response for each grievance review, for up to seven years.

Expedited Review for Immediate or Urgently Needed Services

In place of the formal grievance review described above, you have the right to request an “expedited” review right away when your situation is for immediate or urgently needed services. Blue Cross Blue Shield will review and respond to grievances for immediate or urgently needed services as follows:

When your grievance review concerns medical care or treatment for which waiting for a response under the grievance review time frames described above would seriously jeopardize your life or health or your ability to regain maximum function as determined by Blue Cross Blue Shield or your physician, or if your physician says that you will have severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance review, Blue Cross Blue Shield will review your grievance and notify you of the decision within 72 hours after your request is received.

When a grievance review is requested while the member is an inpatient, Blue Cross Blue Shield will complete the review and make a decision regarding the request before the patient is discharged from that inpatient stay. Coverage for those services in dispute will continue until this review is completed.

A decision to deny payment for health care services may be reversed within 48 hours if the member’s attending physician certifies that a denial for those health care services would create a substantial risk of serious harm to the member if the member were to wait for the outcome of the normal grievance process.

A grievance review requested by a member with a terminal illness will

be completed within five working days of receiving the request. In this case, if the expedited review results in a denial for health care services or treatment, Blue Cross Blue Shield will send a letter to the member within five working days that explains the specific medical and scientific reasons for the denial and a description of alternative treatment, health care services, and supplies that would be covered and information about requesting a hearing. When the member requests a hearing, the hearing will be held within ten days (or within five working days if the attending physician determines after consultation with Blue Cross Blue Shield’s Medical Director and based on standard medical practice that the effectiveness of the health care service, supply, or treatment would be materially reduced if it were not furnished at the earliest possible date). You and/or your authorized representative(s) may attend this hearing.

Appeals Process for Rhode Island Residents or Services

You may also have the right to appeal as described in this section when a claim is denied as being not necessary and appropriate. If so, these rights are in addition to the other rights to appeal that you have as described in other parts of this handbook. The following provisions apply only to:

A member who lives in Rhode Island and is planning to obtain services that Blue Cross Blue Shield has determined are not necessary and appropriate.

A member who lives outside Rhode Island and is planning to obtain services in Rhode Island that Blue Cross Blue Shield has determined are not necessary and appropriate.

Blue Cross Blue Shield decides which covered services are necessary and

appropriate for your dental condition based on a review of your dental records and generally accepted dental practice. Some of the covered services described in this handbook may not be necessary and appropriate for you. If Blue Cross Blue Shield has determined that services are not necessary and appropriate for you, you have the right to the following appeals process.

Reconsideration

Reconsideration is the first step in this appeals process. If you receive a letter denying payment for your dental services, you may request in writing that Blue Cross Blue Shield reconsider its decision by contacting:

Grievance Program
Blue Cross Blue Shield of
Massachusetts
One Enterprise Drive
Quincy, MA 02171-2126
Phone: 1-800-472-2689
Fax: 617-246-3616
Email: grievances@bcbsma.com

You must submit your reconsideration request within 180 days of the adverse decision. Along with your letter, you should include any information that supports your request. Blue Cross Blue Shield will review your request and let you know the outcome of your reconsideration request within 15 calendar days after receipt of all necessary information.

Appeal

An appeal is the second step in this process. If Blue Cross Blue Shield continues to deny benefits for all or part of the original service, you may request an appeal within 60 days of receiving the reconsideration denial letter. Your appeal request should include any information that supports your appeal. You may also inspect and add information to your Blue Cross Blue Shield case file to prepare your appeal. In accordance

with Rhode Island state law, if you wish to review the information in your Blue Cross Blue Shield case file, you must make your request in writing and include the name of a dentist who may review your file on your behalf. Your dentist may review, interpret, and disclose any or all of that information to you. Once received by Blue Cross Blue Shield, your appeal will be reviewed by a dentist in the same specialty as your attending dentist. Blue Cross Blue Shield will notify you of the outcome of your appeal within 15 calendar days of receiving all necessary information.

External Appeal

If your appeal is denied, you have the right to present your case to an appeals agency that is designated by Rhode Island and not affiliated with Blue Cross Blue Shield. If you request this voluntary external appeal, Rhode Island requires you be responsible for half of the cost of the appeal and Blue Cross Blue Shield will be responsible for the remaining half. To file an external appeal, you must send your request in writing to:

Grievance Program
Blue Cross Blue Shield of
Massachusetts
One Enterprise Drive
Quincy, MA 02171-2126
Phone: 1-800-472-2689
Fax: 617-246-3616
Email: grievances@bcbsma.com

Along with your request, you must state your reason(s) for your disagreement with Blue Cross Blue Shield's decision and enclose a check payable to one of the following external appeals agencies: MassPRO (your fee is \$147.50) or the MAXIMUS Center for Health Dispute Resolution (your fee is \$144.20).

Within five working days after the receipt of your written request and payment for the appeal, Blue Cross Blue Shield will forward your request to the external appeals agency along with Blue Cross Blue Shield's portion of the fee and your entire Blue Cross Blue Shield case file. The external appeals agency will notify you in writing of the decision within ten working days of receiving all necessary information.

Expedited Appeal

If your situation is an emergency, you have the right to an expedited appeal at all three levels of appeal as stated above. An emergency requires emergency dental treatment to relieve acute pain or to control a dental condition that requires immediate care to prevent permanent harm to the member. You may request an expedited reconsideration or appeal by contacting Blue Cross Blue Shield at the telephone number shown in your letter. Blue Cross Blue Shield will notify you of the result of your expedited appeal within two working days or 72 hours, whichever is sooner, of its receipt. To request an expedited voluntary external appeal, you must send your request in writing to:

Grievance Program
Blue Cross Blue Shield of
Massachusetts
One Enterprise Drive
Quincy, MA 02171-2126
Phone: 1-800-472-2689
Fax: 617-246-3616
Email: grievances@bcbsma.com

Your request should state your reason(s) for your disagreement with the decision and include signed documentation from your dentist that describes the emergency nature of your treatment. In addition, you must also enclose a check payable to one of the following external appeals agencies: MassPRO (your

fee is \$172.50) or the MAXIMUS Center for Health Dispute Resolution (your fee is \$144.20).

Within two working days after the receipt of your written request and payment for the appeal, Blue Cross Blue Shield will forward your request to the external appeals agency along with Blue Cross Blue Shield's portion of the fee and your entire Blue Cross Blue Shield case file. The external appeals agency will notify you in writing of the decision within two working days or 72 hours, whichever is sooner, of receiving your request for a review.

External Appeal Final Decision

If the external appeals agency upholds the original decision of Blue Cross Blue Shield, this completes the appeals process for your case. But, if the external appeals agency reverses Blue Cross Blue Shield's decision, the claim in dispute will be reprocessed by Blue Cross Blue Shield upon receipt of the notice of the final appeal decision. In addition, Blue Cross Blue Shield will repay you for your share of the cost for the external appeal within 60 days of the receipt of the notice of the final appeal decision.

Disability

If You Incur a Total Disability

If you incur a total disability and begin receiving benefits from the Boston University Long-Term Disability Benefits Plan, on or after January 1, 2016, you may continue your membership in the Boston University Dental Health Plan at the same contribution rate as for active employees for up to five years. The coverage for the BU Dental Health Plan will end as of the end of the 5th year of disability.

If You Die While You Are a Member of the Plan

Your enrolled dependents will be entitled to continue coverage for up to 36 months under COBRA, as described later in this section.

When You Retire

You and your enrolled dependents will be entitled to continue coverage for up to 18 months under COBRA, as described later in this section.

Leaves of Absence and No-Pay Status

If you are on a leave of absence or no-pay status, you must contact Human Resources to ask what impact your absence may have on your participation in the Dental Plan.

- **Leave of Absence with Pay** If you are granted a leave of absence with pay (including sabbatical), your Dental Plan coverage will continue, provided your usual payroll deductions continue.
- **Leave of Absence Without Pay and No-Pay Status** If you are granted a leave of absence without pay or no-pay status, you may continue your Dental Plan coverage during your leave, provided you pay the employee cost of continuing this coverage.

If you choose to continue coverage, you must contact Human Resources before you begin your leave to make the necessary billing arrangements. This coverage will be automatically canceled if you fail to make required payments.

If you do not wish to continue your coverage during your unpaid leave of absence, you may discontinue your membership by obtaining the necessary forms from Human Resources. Re-enrollment in the Boston University Dental Health Plan will be possible when you return from a leave of

absence or no-pay status, as long as you contact Human Resources and enroll within 30 days of the date you return.

The COBRA continuation of coverage provisions would also apply in this situation should you wish to elect COBRA coverage.

When Your Coverage Ends

If your employment with the University terminates for any reason, including retirement, your Dental Plan membership will end on the last day of the month in which your employment terminates.

Once the payroll system reflects the termination of your employment, Human Resources will automatically notify you in writing of your last day of coverage, and of what to do to continue coverage.

In addition to any continuation provisions provided by Boston University, you and your covered dependents have the right to extend your coverage for up to 18 or 36 months under the federal continuation provisions (COBRA) explained in the following section.

Additional Administrative Information.

For additional information such as plan administrative information and your rights under ERISA, please refer to the Administrative Information section of this Handbook.

Coverage Continuation Provisions

A federal law known as COBRA requires that most employers sponsoring group dental health plans offer employees and their families (“qualified beneficiaries”) the opportunity to elect and pay for a temporary extension of dental health coverage called “continua-

tion coverage” at group rates in certain instances (“qualifying events”) where coverage under the employer’s dental health plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of that law. (Both you and your spouse should take time to read this notice carefully.) Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for the coverage.

If you are an employee of the Plan Sponsor (Boston University) covered by one of the dental health plan options maintained by the Plan Sponsor (the “Plan”), you will become a qualified beneficiary if you lose your group dental health coverage because either one of the following qualifying events happens:

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

If you are the spouse of an employee covered by the Dental Plan, you will become a qualified beneficiary if you lose your coverage under the Dental Plan because any one of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse’s hours of employment are reduced;
- You become divorced or legally separated from your spouse; or
- Your spouse becomes entitled to Medicare (under Part A, Part B, or both).

Your dependent children will become qualified beneficiaries if

they lose coverage under the Dental Plan because any one of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); or
- The child ceases to be eligible for coverage under the Plan as a "dependent child."

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 the Dental Plan Sponsor and that bankruptcy results in the loss of coverage of any retired employee covered under the Dental Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse or surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Dental Plan.

When Is COBRA Coverage Available?

The Dental Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A,

Part B, or both), the Plan Sponsor must notify the Plan Administrator of the qualifying event.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Instead of enrolling in COBRA continuation coverage, there may be other, more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group dental health plan coverage (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Contact listed at the end of this summary, along with documentation substantiating the

divorce, legal separation, or loss of dependent status and the effective date of such event.

A child who is born to or placed for adoption with the covered employee during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary and be added to the covered employee's COBRA continuation coverage. You must notify the Plan Administrator within 60 days after the birth or placement for adoption occurs. You must provide this notice to the Plan Contact listed at the end of this summary, along with copies of legal documents substantiating the birth or placement for adoption and the effective date of such event.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the Plan Administrator that you want to elect continuation coverage. If you do not elect continuation coverage, your group dental health coverage will end. If you elect continuation coverage, the Plan Sponsor is required to permit you to elect and purchase coverage which, as of the time coverage is being provided, is identical to the coverage provided

under the Plan to similarly situated employees or family members.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce, legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Dental Plan is determined by the Social Security Administration to be disabled (for purposes of Title II [OASDI] or Title XVI [SSI] of the Social Security

Act) and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The qualified beneficiary must also notify the Plan Administrator within 30 days of the date of any final determination by the Social Security Administration that he or she is no longer disabled. You must provide these notices to the Plan Contact listed at the end of this summary, along with copies of correspondence from the Social Security Administration substantiating the disability/loss of disability and the effective date of the applicable SSA determination. Furthermore, during the period after the 18th month through the 29th month of continuation coverage, the monthly premium cost will be increased to 150% of the applicable premium relating to continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. You must provide this notice to the Plan Contact listed at the end of this summary, along with copies of documentation substantiating the second qualifying event. This exten-

sion may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, legally separated, or if the dependent child stops being eligible under the Dental Plan as a dependent child, but 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.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary must pay the entire cost of continuation coverage. The amount a qualified beneficiary must pay may not exceed 102% (or, in the case of an extension of continuation coverage due to disability, 150%) of the cost to the Dental Plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

When and How Must Payment for COBRA Continuation Coverage Be Made?

First Payment for Continuation Coverage

If you elect continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the election notice is postmarked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is

correct. You may contact the party responsible for COBRA administration under the Plan at the address, phone number, or email address provided at the end of this section to confirm the correct amount of your first payment.

Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break.

Grace Period for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the

periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

Early Termination of COBRA

COBRA provides that your continuation coverage may be terminated before the end of the maximum coverage period for *any* of the following reasons:

- The Plan Sponsor no longer provides group dental health coverage to any of its employees;
- Any required premium for continuation coverage is not paid in full on time;
- A qualified beneficiary becomes covered—after electing COBRA continuation coverage—under another group dental health plan (as an employee or otherwise) that does not impose any pre-existing condition limitation for a pre-existing condition of the qualified beneficiary;
- A qualified beneficiary becomes entitled to Medicare (under Part A, Part B, or both) after electing COBRA continuation coverage;
- A qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group dental health plans may impose pre-existing condition limitations. HIPAA coordinates COBRA's other coverage cut-off rule (in the third bullet above) with these new limits as follows:

If you become covered by another group dental health plan and that

plan contains a pre-existing limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the Plan Sponsor may terminate your COBRA coverage.

You do not have to show that you are insurable to choose continuation coverage. However, as discussed above, you will have to pay all the required premiums for your continuation coverage.

The law also says that, at the end of the 18-month, 29-month, or 36-month continuation coverage period, you must be allowed to enroll in an individual conversion dental health plan if such an individual conversion dental health plan is otherwise generally available under the Plan.

COBRA continuation coverage may be terminated for any reason if the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

If You Have Questions

More complete information regarding your COBRA continuation coverage rights is available from the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.)

Plan Contact Information (Plan Administrator)

COBRA Administrator:
P&A Group
Dept. #652
P.O. Box 8000
Buffalo, NY 14267-8000
1-800-688-2611

