

Duke Dental Program

Coverage provided and underwritten by
Ameritas Life Insurance Corp.





Duke Dental Program

The coverage for the Duke Group Dental Insurance Program is provided and underwritten by Ameritas Life Insurance Corp. Duke offers you a choice of two plans under this program, depending on the level of coverage you and your family may need. Both plans cover Type 1 (preventive), Type 2 (basic), and Type 3 (major) services, but they differ in how they pay for covered services.

While you have the freedom to visit any licensed dentist of your choice, you may also choose from a limited network of providers who have agreed to accept a usual and customary (U&C) amount for covered services. You can find a PPO network provider by calling Ameritas at 1-800-755-8844 or by visiting www.ameritasgroup.com/duke.

The term “Duke” is used throughout this document. For purposes of this Benefit Program description, “Duke” refers to the University, Duke University Health System, Inc., and any other entity which is or becomes controlled by Duke University and where, upon appropriate action by the Board of Trustees, the employees of that entity are included in the membership of this program.

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Group Dental for Duke Employees and Their Families

Coverage and Limitations Comparison Chart

Below and on the following page is a comparison chart of the two Duke dental options — Plan A and Plan B:

Service	Procedures	Plan A	Plan B
Type 1 (Preventive) ¹	2 exams per year	100% of U&C ² No deductible	Benefits based on the <i>Schedule for Plan B</i> (sample begins on page 41)
	2 cleanings per year		
	Space maintainers		
	X-rays		
	Fluoride treatment (for children under age 19)		
Type 2 (Basic)	Extractions and fillings	Based on benefit payable levels	Benefits based on the <i>Schedule for Plan B</i> (sample begins on page 41)
	Full or partial denture repair	\$100 lifetime deductible per person	
	Sealants		
	Anesthesia (with surgical procedures)		\$50 calendar year deductible on Type 2 (basic) & Type 3 (major) procedures, combined
	Periodontics (gum diseases)		
	Endodontics (root canals)	BENEFIT PAYABLE LEVELS ³	
	Level 1 80% of U&C ² Level 2 90% of U&C ² Level 3 100% of U&C ²	N/A	

1 No benefits will be paid for expenses incurred by late entrants during the first six months an insured is covered, except for exams, cleanings, and fluoride applications. A late entrant is any person who did not enroll within 60 days from date of employment or within 30 days from the date the person qualified for insurance, or any person who has elected to become insured again after terminating coverage.

2 All payments are based on the usual and customary (U&C) allowable charge. You are liable for charges over U&C.

3 Level 1 applies during the first calendar year that you are insured. You must visit a dentist during each calendar year and have one covered procedure performed in order for Level 2 reimbursement to apply during the second calendar year and Level 3 reimbursement to apply each calendar year thereafter.

If during any calendar year you fail to visit a dentist or fail to have one covered procedure performed, Level 1 reimbursement will automatically reapply during the following calendar year and you must advance to Levels 2 and 3 as if you were newly insured.

Exception: If during any calendar year you have a break in continuous coverage of more than one month, Level 1 reimbursement will reapply for the balance of that calendar year and you must advance to Levels 2 and 3 as if you were newly insured.

PLEASE NOTE: If you have already achieved the highest benefit payable, Level 3, you will remain at that level as long as you continue to visit a dentist at least one time each calendar year.

Service	Procedures	Plan A	Plan B
Type 3 Major	Pontics (false tooth) and bridges Crown and bridge repair Dentures and partial dentures Crowns Onlays	50% of U&C ¹ \$50 calendar year deductible per person	Benefits based on the <i>Schedule for Plan B</i> (sample begins on page 43) \$50 calendar year deductible on Type 2 (basic) & Type 3 (major) procedures combined
Maximum Deductibles	N/A	N/A	3 deductibles per family per year
Maximum Benefit	N/A	\$1,000 per person per year ² Types I and Type II, combined	\$750 per person per year ² Types 1, 2 and 3, combined
Orthodontia	Please Note: Benefits payable only if treatment begins after the participant becomes covered by the Duke Dental Plan	2-year treatment 50% of U&C ¹ No deductible \$1,000 lifetime max. per person (adults and children) Benefits paid on a quarterly basis	2-year treatment 50% of U&C ¹ No deductible \$750 lifetime max. per person (adults and children) Benefits paid on a quarterly basis

1 All payments are based on the usual and customary (U&C) allowable charge. You are liable for charges over U&C.

2 Ameritas Dental Rewards®: Dental plan members who visited the dentist and had at least one dental claim filed in calendar year 2006, with less than \$500 in claims payments, will have their annual maximum benefit increased by \$250 in 2007. This accumulation can continue until the annual maximum has increased on Plan A from \$1,000 to \$2,000; on Plan B, from \$750 to \$1,750.

Please see pages 40–41 for claims payment examples and page 44 for a list of ineligible expenses.

Eligibility and Enrollment

Eligibility

You are eligible for dental coverage if you are a:

- Regular employee who works at least 20 hours per week and who is included in a payroll/benefit classification designated by Duke as eligible to apply for coverage under the Group Dental Insurance Program.

Eligible Dependents

The following dependents are eligible for enrollment in a Duke Dental Program:

- Your legal spouse or same-sex spousal equivalent,
- Your unmarried dependent children (includes natural children, stepchildren, adopted children, foster children, or children for whom you are legal guardian up to age 19, or up to the 26th birthday if unmarried, full-time students. Dependent children does not include grandchildren, siblings, or other family members, or children of whom you have legal custody), and
- Your children who are mentally or physically disabled and incapable of self-support after age 19, as long as:
 - Their disability began before they turned age 19,
 - They had continuous coverage under a Duke dental plan prior to age 19, and
 - A handicapped dependent form is submitted to and approved by the Dental Plan prior to the 19th birthday.

Collective Bargaining Agreements

Group dental insurance benefits are a subject of good faith bargaining between Duke and certain employee representatives. The plan is maintained pursuant to certain collective bargaining agreements. The agreements are available for your inspection in the Staff and Labor Relations Department of Duke's Human Resources, 144 Trent Drive Hall, Durham, NC.

Enrolling

You have 60 days from the date of employment to enroll in the Group Dental Insurance Program.

If you do not enroll when you are first eligible (within 60 days of employment or eligibility), you can enroll during the annual Open Enrollment period. You and your dependents will be late entrants and will be covered for exams, cleanings, and fluoride applications during the first six months of coverage. After the first six months, you will be entitled to full benefits as defined by the Group Dental Insurance Program. Children enrolled during an Open Enrollment period within six months of turning age two are not subject to the late entrant penalty.

After you select between Dental Plan A or B, there are several types of coverage in which you may enroll:

- Employee Only Coverage (Individual)
- Employee and Spouse/Same-Sex Spousal Equivalent
- Employee and Child
- Family

PLEASE NOTE: Once you enroll in a particular type of coverage, you cannot stop or change your election until the next annual Open Enrollment period, unless you experience a qualifying event. Qualifying events include, but are not limited to, birth, marriage, divorce, death of a spouse or child, or termination of employment. To participate, eligible dependents must enroll within 30 days of the qualifying event or they will be considered late entrants.

A calendar year, January 1 to December 31, is the basis for your deductibles, maximums, and coinsurance levels. During the first year you are insured, your calendar year is from your effective date through December 31 of that year.

Effective Date of Coverage

New employees of Duke University and Duke University Health System are eligible for coverage effective on the:

- First day of employment/eligibility with Duke, or
- First day of the second full month of employment/eligibility.

Cost of the Plan

Eligible employees covered under the plan pay the entire premium for their benefits under the plan in such amounts as determined solely by the insurance company, Ameritas. Premium payments are required to be paid on a before-tax basis through the Duke University Premium Conversion and Flexible Reimbursement Accounts Plan.

When Coverage Ends

Member Terminations

Your membership in the Plan, and coverage under the Plan, may be terminated and written notice will be provided for any of the following reasons:

- Fraud or misrepresentation. This includes but is not limited to fraudulent statements or material misrepresentations of fact made on your enrollment application, including enrollment of ineligible dependents;
- Fraudulent use of services or facilities;
- Misuse of your identification card. This includes but is not limited to allowing someone else to use your Plan identification card;
- Nonpayment of your contribution toward coverage under the Plan; or
- Marriage of a surviving spouse.

The Plan is entitled to recover all expenses it incurs (including the reasonable value of services received, reasonable attorney's fees and any incidental expenses) because of fraud, misuse or misrepresentation from the member who committed such fraud, misuse or misrepresentation.

Termination of Coverage

Members may not terminate coverage under the Plan except during the annual Open Enrollment period or within 30 days of a valid change in family status.

Subject to your continuation rights under COBRA, your Plan coverage will terminate if you lose your eligibility to be a member, or if the employee through whom you are enrolled in the Plan loses his/her Plan coverage. If you cease to be eligible to participate in the Plan because of an amendment to the Plan by Duke University, your coverage will terminate the date the amendment to the Plan takes effect. Coverage for all the members enrolled through an employee who loses his or her eligibility because of a Plan amendment will terminate the date the amendment takes effect. Coverage for all Plan members will terminate as of the date Duke terminates the Plan.

How the Dental Program Works

Coverage

Coverage and deductibles vary according to the plan you choose, the procedures you receive and, if you select Plan A, the benefit payable level (Level 1, Level 2, or Level 3). Please refer to the comparison charts on pages 34–35 for a broad overview of the available benefits. Also, please read the following information about deductibles and benefits for a more detailed explanation.

Deductibles

A deductible is the amount of covered expenses for which no benefits are paid. Benefits will be paid only for covered expenses which exceed the deductible.

For both Plans A and B there is no deductible for Type 1 (preventive) procedures.

The Plan A Type 2 (basic) procedures deductible applies per person, but only once during his or her lifetime. The Plan A Type 3 (major) procedures deductible amount applies per person each calendar year.

Plan B has a different deductible structure. In Plan B, Type 2 and Type 3 deductibles are combined and apply to each person each calendar year.

Maximum Benefit

The maximum benefit per calendar year is the most that will be paid for covered expenses incurred by each person covered during each calendar year. The calendar year is January 1 to December 31. The maximum benefit per calendar year is \$1,000 for Plan A and \$750 for Plan B.

Ameritas Dental Rewards®: Dental plan members who filed at least one claim in a calendar year, with less than \$500 in claims payments, will have their annual maximum benefit increased by \$250 beginning in 2006. This accumulation can continue until the annual maximum has increased on Plan A from \$1,000 to \$2,000; on Plan B, from \$750 to \$1,750.

Covered Expenses

For all of Plan A and the orthodontic procedures of Plan B, covered expenses are the usual and customary (U&C) expenses, as determined by Ameritas, the dental plan underwriter. Such expenses are shown on the List of Dental Procedures in your plan certificate (issued to you after enrollment in the plan).

These expenses will be covered only for procedures done by a dentist or dental hygienist. These expenses are subject to the “Ineligible Expenses” listed on page 44. **If two or more procedures can be used as an appropriate treatment to correct a certain condition, the amount of the covered expense will be the charge for the least expensive procedure.**

For the Type 1, Type 2, and Type 3 procedures of Plan B, covered expenses will not exceed the schedule amount shown for procedures listed in your plan certificate.

Expenses Incurred

An expense is incurred at the time the service is rendered or a supply is furnished, the impression is made for an appliance or change to an appliance, the tooth or teeth are prepared for a crown, bridge or gold restoration, or the pulp chamber is opened for root canal therapy.

Plan A Incentive Program

With Plan A, Duke offers a special “incentive program” to motivate you and your family to establish and continue an ongoing program of preventive care. During the first calendar year of Plan A, all Type 2 procedures, subject to the application of the deductible, will be covered at 80% coinsurance of plan allowance (Level 1). If you have at least one procedure performed within the first calendar year, the reimbursement level will be INCREASED to 90% coinsurance of plan allowance in the second calendar year (Level 2). As long as you continue to visit the dentist each calendar year and have at least one procedure performed within the given calendar year, the reimbursement level will continue to increase to where in the third year of coverage all Type 1 and Type 2 eligible covered expenses are reimbursed at 100% coinsurance of plan allowance (Level 3). Should you fail to visit the dentist in any calendar year, or should you fail to have at least one covered procedure performed within the given calendar year, the reimbursement percentage for Type 2 procedures will return to 80% and the incentive program will begin again the following calendar year.

Covered Procedures

Major categories are shown for Plans A and B. See *page 44* for late entrant information under “Ineligible Expenses.”

Type 1 (Preventive) Procedures

No deductibles

- **Oral Exams:** Two treatments per calendar year.
- **Prophylaxis (cleaning):** Two treatments per calendar year.
- **Fluoride Treatment:** One treatment per year for children under age 19.
- **X-rays:** Entire denture series, panoramic survey (one in any three-year period), bitewing films (two treatments per calendar year).
- **Pathology:** Biopsy of oral tissue and histopathologic examination.
- **Space Maintainers:** Fixed and removable.

Type 2 (Basic) Procedures

Deductibles: Plan A – \$100 lifetime; Plan B – \$50 calendar year, Types 2 and 3 combined

- **Emergency Exams:** Necessitated as the result of an accidental injury.
- **Sealants:** Limited to treatment of permanent molars only once in any 36-month period for children under 17.
- **Oral Surgery:** Extractions, impacted teeth, alveolar or gingival reconstruction, cysts, and neoplasms.
- **General Anesthesia:** Not available without a cutting procedure.
- **Periodontics:** Root planing, gingivectomy, subgingival curettage.
- **Restorative Dentistry:** Amalgam restorations, silicate restorations, resin restorations, recementations, full and partial denture repair.
- **Endodontics:** Root canals.

How the Dental Program Works

Type 3 (Major) Procedures

Deductibles: Plan A – \$50 calendar year; Plan B – \$50 calendar year, Types 2 and 3 combined

- **Restorative:** Inlays, onlays, and crowns.
- **Prosthodontics – Fixed:** Bridge abutments, pontics, and repair of crowns and bridges.
- **Prosthodontics – Removable:** Partial and complete upper and lower dentures, stress breaker, upper and lower stayplate, addition of teeth to partial denture.

Orthodontic Expense Benefits

Coverage will be paid for the length of the treatment indicated, not to exceed 24 months. See “Ineligible Expenses” #19, #20, and #21 on page 44.

Orthodontic Treatment

Orthodontic treatment means the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

Treatment Program

Treatment program means an interdependent series of orthodontic services prescribed by a physician to correct a specific dental condition. A **program will start when the active appliances are inserted.** A program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

Expenses Incurred

An orthodontic expense is incurred:

- At the end of every quarter (three-month period) of treatment for a person who pursues an orthodontic program, but not beyond the date the treatment ends, or
- At the time the service is rendered for a person who incurs covered expenses but does not pursue a treatment program.

Benefit Calculation

Benefits will be payable when a covered expense is incurred. The covered expenses are based on the estimated cost of the patient’s treatment program.

Payments are pro-rated by quarter (three-month periods) over the estimated length of the program, but not for more than eight quarters, and multiplied by the orthodontic benefit percentage (50%). The last quarterly payment for a treatment may be changed if the estimated and actual cost of the treatment differs.

Coordination with Duke Reimbursement Accounts

It is recommended that you contact WageWorks if you want to use both the Health Care Reimbursement Account and the Dental Program to cover the orthodontia expenses for a dependent child. WageWorks administers the Reimbursement Account Programs and can be reached at (877) 924-3967.

Ineligible Orthodontia Expenses

Covered expenses exclude and no benefits will be paid for expenses incurred:

- For a treatment program which began before the insured became covered for orthodontic expense benefits, or
- After the individual’s insurance for orthodontic benefits terminates.

Sample Comparison of Plan A and Plan B Coverage

The hypothetical examples on the next page summarize the benefit you can expect to receive, depending on the plan you choose. Each example highlights either Type 1, Type 2 or Type 3 procedures. The examples include the benefit you can expect to receive if you elect either Plan A or Plan B.

The rates and benefits for Plan B have been designed to provide a quality, basic benefit. Plan A provides a more comprehensive benefit. These two plans were chosen by Duke to give employees and dependents the choice of a benefit and/or price range that best suits their needs.

In the following examples it is assumed that the deductible, if applicable, has been satisfied.

Sample Comparison of Plan A and Plan B Coverage

In the following hypothetical examples, it is assumed that the deductible, if applicable, has been satisfied. These examples are for illustrative purposes only. Plan members should refer to the plan Certificate for the current, complete list of covered procedures.

Example 1

Ellen visited the dentist for a periodic exam (ADA procedure code D0120) and cleaning (ADA procedure code D1110). The dentist's charge for the periodic exam was \$25.00, the cleaning was \$50.00, making the total dentist's charge \$75.00. Both of these procedures are considered Type 1 (preventive) procedures.

If Ellen elected **Plan A**, her reimbursement from Ameritas would be calculated like this:

Dentist Charge	\$75.00
Coinsurance Level	100%
Amount Paid by Plan	\$75.00
Amount Due Dentist	\$ 0.00

If Ellen elected **Plan B**, her reimbursement from Ameritas would be calculated like this:

Dentist Charge	\$75.00
Amount Allowed by Schedule	\$60.60
Amount Due Dentist	\$14.40

Example 2

Joe visited the dentist to have a tooth filled (ADA procedure code D2150). The dentist's charge for this two-surface procedure was \$74.00. This procedure is considered a Type 2 (basic) procedure.

If Joe elected **Plan A**, his reimbursement from Ameritas would be calculated like this:

Dentist Charge	\$74.00
Coinsurance Level	90%
Amount Paid by Plan	\$66.60
Amount Due Dentist	\$7.40

If Joe elected **Plan B**, his reimbursement from Ameritas would be calculated like this:

Dentist Charge	\$74.00
Amount Allowed by Schedule	\$33.15
Amount Due Dentist	\$40.85

Example 3

Susan visited the dentist for a crown on her front tooth (ADA procedure code D2752). The dentist recommended a porcelain fused to noble metal crown. The dentist's charge was \$575.00. This procedure is considered a Type 3 (major) procedure.

If Susan elected **Plan A**, her reimbursement from Ameritas would be calculated like this:

Dentist Charge	\$575.00
Coinsurance Level	50%
Amount Paid by Plan	\$287.50
Amount Due Dentist	\$287.50

If Susan elected **Plan B**, her reimbursement from Ameritas would be calculated like this:

Dentist Charge	\$575.00
Amount Allowed by Schedule	\$160.00
Amount Due Dentist	\$415.00

Sample Procedure List for Plan A

The following is a sample list of dental procedures for which benefits are payable under Plan A. The amount that Ameritas pays per procedure is based on the usual & customary fees in the ZIP code area where the procedure is performed. (This sample applies to dentists located in areas where the ZIP code begins with 277 and may not reflect the fees charged in other areas.) All services are subject to coinsurance, deductible, and plan provisions. These examples are for illustrative purposes only. Plan members should refer to the plan Certificate for the current, complete list of covered procedures.

Current Dental Terminology © American Dental Association.

Procedure Number	Procedure	Maximum Payment
D0120	Periodic oral evaluation	\$35.00
D1120	Prophylaxis – child (<i>cleaning</i>)	\$49.00
D1110	Prophylaxis – adult (<i>cleaning</i>)	\$68.00
D0330	Panoramic film	\$87.00
D0272	Bitewings – two films	\$33.00
D4910	Periodontal maintenance	\$97.00
D2140	Amalgam – one surface, primary or permanent	\$85.00
D2330	Resin-based composite – one surface, anterior	\$99.00
D3320	Root canal, bicuspid (excluding final restoration)	\$615.00
D7140	Extraction, erupted tooth or exposed root	\$98.00
D7210	Surgical removal of erupted tooth	\$191.00
D2751	Crown – porcelain fused to predominantly base metal	\$702.00
D5214	Mandibular partial denture	\$933.00

Sample Schedule for Plan B

The following is a sample list of dental procedures for which benefits are payable under Plan B. Any dollar amount is a maximum covered expense. Please read the section “Ineligible Expenses” on page 44 for additional coverage information. Please refer to your Certificate for the current, complete list of covered procedures.

Current Dental Terminology © American Dental Association.

TYPE 1 (PREVENTIVE) PROCEDURES

Proc. no.	Procedure	Maximum Payment
D0120	Periodic oral evaluation	\$18.18
D1120	Prophylaxis – child	\$30.30
D1110	Prophylaxis – adult (age 14 and over)	\$42.42
D0330	Panoramic film	\$54.54
D0272	Bitewings – two films	\$18.18

TYPE 2 (BASIC) PROCEDURES

Proc. no.	Procedure	Maximum Payment
D4910	Periodontal maintenance	\$62.40
D2140	Amalgam – one surface, primary or permanent	\$23.40
D2330	Resin-based composite – one surface, anterior	\$25.35
D3320	Root canal, bicuspid (excluding final restoration)	\$195.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$23.40
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$35.10

TYPE 3 (MAJOR) PROCEDURES

Proc. no.	Procedure	Maximum Payment
D2751	Crown – porcelain fused to predominantly base metal	\$160.00
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$224.00

How the Dental Program Works

Ineligible Expenses

Covered expenses exclude and no benefits will be paid for expenses incurred:

1. By late entrants, during the first six months the insured is covered, except for exams (excluding x-rays), cleanings, and fluoride applications.
A late entrant is every person:
 - a. who did not enroll within 60 days from the date of employment or within 30 days from the date the person qualified for insurance; or
 - b. who has elected to become insured again after terminating coverage.
2. For any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the second bicuspid are considered cosmetic.
3. To replace any crown, bridge, onlay, partial denture, or full denture which was originally placed fewer than five years ago, regardless if the original prosthetic was covered under the plan. However, if the replacement is due to an accidental injury sustained while covered under this plan, it will be a covered expense.
4. For any bridge, partial denture, or complete denture needed because of an extraction of a natural tooth that occurred while the person was not insured under this plan. For the appliance or bridge to be eligible for coverage, the tooth must be extracted while the person is insured under this coverage and must include the replacement of the extracted tooth or teeth. The extraction of wisdom teeth (third molars) does not qualify for replacement.
5. For any procedure begun before a person becomes insured.
6. For any procedure begun after a person's insurance terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after a person's insurance terminates.
7. To replace lost or stolen appliances.
8. For appliances, restorations, or procedures to alter vertical dimension, restore or maintain occlusion, splint or replace tooth structure lost as a result of abrasion or attrition.
9. For any procedure which is not shown on the Table of Dental Procedures in your Certificate of Insurance.
10. For education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene, or dental plaque control.
11. For the completion of claim forms.
12. For sealants which are:
 - a. not applied to a permanent molar,
 - b. applied after attaining age 17, or
 - c. reapplied to a molar within three years from the date of a previous sealant application.
13. Subgingival curettage or root planing unless the presence of periodontal disease is confirmed by both x-rays and pocket depth summaries of each tooth involved.
14. Because of an injury or sickness arising out of, or in the course of, work for wage or profit or that is eligible for benefits under any Workers' Compensation act or similar law.
15. For charges for which a person is not liable or which would have not been made had no insurance been in force.
16. For services which are not recommended by a dentist or which are not required for necessary care and treatment.
17. Because of war or any act of war, declared or not.
18. By a person if payment is not legal where the person is living when expenses are incurred.
19. For a treatment program which began before the insured became covered for orthodontic expense benefits.
20. After the individual's insurance for orthodontic benefits terminates.
21. For operating rooms and other facility charges.
22. For general anesthesia, unless administered in a dental office and in conjunction with a cutting procedure.

Coordination of Benefits

If you or any of your dependents incur charges which are covered by any other group plan, the benefits of this plan will be coordinated with the benefits of the other plan so that the total benefits received are not greater than the charges incurred.

Continuation of Benefits

If you are covered by the Group Dental Insurance Program at the time you leave Duke, you may continue coverage under the following circumstances:

- Upon retirement from Duke after satisfying the retiree dental eligibility criteria, which is described in the *Duke Retirement Planning Guide*,
- If you become totally disabled and are receiving benefits from Duke under the Duke Disability Program,
- Upon termination or change in eligibility, you may continue coverage under COBRA for you and your covered dependents.

Estimate of Payment

If your dentist thinks charges for the proposed work will be \$200 or more, you and your dentist can complete a claim form for pre-statement of benefits. Your dentist shows the work to be done and what the charges will be. The claim form is then sent to Ameritas. Ameritas will estimate your benefits and send a report to your dentist.

How to File A Claim

Claims Procedure

Ameritas provides each employee with a Certificate of Insurance explaining the plan benefits and limitations in complete detail. For claim forms or answers to your questions, call toll-free, (800) 487-5553.

Follow the steps below to file a claim:

1. Upon enrollment, a claim form is included with your Certificate of Insurance. Additional claim forms can be obtained from your Human Resource Information Center (HRIC), Ameritas, or the Duke web site (www.hr.duke.edu).
2. Take the claim form with you to the dentist performing your service.
3. You complete Parts 1 and 3 of the claim form. Part 1 is information about you and your employer. Part 3 allows you to have benefits paid directly to your dentist.
4. Your dentist completes Parts 2 and 4. Part 2 identifies the services that were performed. Part 4 certifies that the dentist performed the services.
5. You or your dentist can send the claim form to:
Ameritas Life Insurance Corp.
Group Dental Claims
P.O. Box 82520
Lincoln, NE 68501-2520

We will evaluate your claim promptly after we receive it. Within 30 days after we receive your claim we will send you: (a) a written decision on your claim; or (b) a notice that we are extending the period to decide your claim for an additional 15 days. If the extension is due to your failure to provide information necessary to decide the claim, the extended time period for deciding your claim will not begin until you provide the information or otherwise respond.

If we extend the period to decide your claim, we will notify you of the following: (a) the reasons for the extension; (b) when we expect to decide your claim; and (c) any additional information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of the denial containing:

- The reasons for our decision,
- Reference to any part of the Duke Group Dental Insurance policy on which our decision is based,
- Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request,
- A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of dental practice,
- A description of any additional information needed to support your claim,
- Information concerning your right to a review of our decision, and
- Information concerning your right to bring a civil action for benefits under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if your claim is denied on review.

Claims Review Procedure

If all or part of a claim is denied, you may request a review.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your request for review. There will be no charge for such copies. You may request the names of the experts we have consulted who provided advice to us about your claim.

The person conducting the grievance review will be someone other than the person who denied the claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request. Within at least 60 days after we receive your request for review we will send you a written decision on review.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

- The reasons for our decision,
- Reference to the parts of the Duke Dental Group Insurance policy on which our decision is based,
- Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request,
- Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim,

- A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of dental practice, and
- Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Appeals of Eligibility, Right to Participate, and Other Claims Not Directly Related to Benefit Payments

With respect to all claims or issues not subject to the claims procedures described for the plan, such as your right as an eligible employee or dependent to apply for coverage under the plan, you may make a claim by filing a written claim and proof of claim with the Plan Administrator in accordance with procedures and guidelines established from time to time by the Staff Fringe Benefits Committee (the Committee). The Plan Administrator will decide whether the claim will be allowed. Send your claim to:

**Dental Plan Administrator
Duke Benefits
705 Broad St.
Box 90502
Durham, NC 27708**

Within 90 days after receipt of a proof of claim by the Plan Administrator, as appropriate, or within 180 days if special circumstances require an extension of time, you will be notified of the decision with regard to your claim. In the event of special circumstances requiring an extension of time, written notice of the extension will be furnished to you prior to expiration of the 90-day period, setting forth the special circumstances and the date the decision will be furnished. If the claim is wholly or partially denied, notice thereof will be in writing and worded in a manner for you to understand. Such notice will set forth:

- The specific reason(s) for the denial,
- Specific reference to pertinent plan provisions

How to File A Claim

on which the denial is based,

- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, and
- An explanation of the procedure for review of the denied claim.

If you are not notified of the decision concerning your claim in a timely manner, the claim will be deemed denied as of the close of the initial 90-day period (or the close of the extension period, if applicable). If you wish to appeal the denial, follow the instructions below.

Claims Review Procedure

Within 60 days following your receipt of notice from the Plan Administrator denying the claim in whole or in part or, if such notice is not given, within 60 days following the latest date on which such notice could have been timely given, you may appeal the denial of the claim by filing a written application for review with the Committee.

Send your appeals to:

**Staff Fringe Benefits Committee
Duke Benefits
705 Broad St.
Box 90502
Durham, NC 27708**

Following such request for review, your appeal of the decision denying your claim will be fully and fairly reviewed. Prior to reaching a decision concerning your appeal, you will be given an opportunity to review pertinent documents and submit issues and comments in writing.

The decision on review of a claim denied in whole or in part will be made within 60 days following receipt of the request for review, or within 120 days if special circumstances require an extension of time, and you will be notified in writing of the decision. If special circumstances require an extension of time, written notice of the extension will be furnished to you prior to commencement of the extension. If the decision on review is not furnished in a

timely manner, your claim will be deemed denied as of the close of the initial 60-day period, or the close of the extension period, if applicable.

If a claim is denied in whole or in part, the decision on review will set forth specific reasons for the decision written in a manner for you to understand, and will cite pertinent plan provisions on which the decision is based. The decision on review of your claim by the Committee will be final and conclusive.

Any action required to be taken by you during the claims procedure or claims review procedure may be taken by a representative acting on your behalf. You may be required to provide evidence to verify the authority of any such representative to act on your behalf. Neither you nor your representative has the right to be present during the consideration of any appeal from the initial denial of your claim.

Authority of the Committee and the Plan Administrator

Both the Committee and the Plan Administrator have the duty and discretionary authority to interpret and construe the eligibility provisions of the plan, subject to the objective terms of the plan. Interpretations and determinations made by the Committee and the Plan Administrator will be applied uniformly to all persons similarly situated and will be binding and conclusive upon each eligible employee and dependent who is covered under the plan and any other interested person. Such interpretations and determinations made by the Committee and the Plan Administrator will only be overruled by a court of law if the Committee and the Plan Administrator are found to have acted arbitrarily and capriciously in interpreting and construing the provisions of the plan. See the "General Information" section of this booklet for:

- A summary of your rights under the Employee Retirement Income Security Act of 1974 (ERISA),
- Information about COBRA continuation coverage, and
- Administrative and other general information about this plan.

Other Information

It is intended that the Duke Dental Program qualify as an “accident and health plan” under federal tax laws. This Benefit Program Description, which is a part of the Duke University Welfare and Fringe Benefit Plan along with the underlying insurance contracts, shall constitute the written plan document for the Duke Dental Program. It is further intended that benefits payable under the Duke Dental Program be eligible for exclusion from gross income. Duke reserves the right to change or terminate these benefits or your eligibility for benefits under the Duke Dental Program. The written plan documents for the Duke Dental Program are not employment contracts or any type of employment guarantee.

Notes