# THE INDEMNITY DENTAL BENEFITS PLAN


**THE UNIVERSITY SYSTEM OF GEORGIA**

Plan Design – Originated January 1, 1994
Booklet Revised – November 2010
Effective Date – January 1, 2011

# Resource Contacts

Should you have questions regarding your indemnity dental benefits plan, please contact the appropriate resource(s) identified below:

| For Questions About | Please Contact | Location |
|---|---|---|
| **Coverage Provided by the Plan** | Campus Human Resources/ Personnel Office<br><br>Dental Claims Unit<br><br>MetLife MyBenefits website (you must register on the site to access plan information) | Your Institution<br><br>1-866-832-5759<br>TDD 1-800-855-2880<br><br>www.metlife.com/mybenefits |
| **Participating Providers**<br>For information regarding the participating providers in the MetLife Preferred Dentist Program<br><br>The MetLife Preferred Dentist Program includes dental providers within the State of Georgia, as well as, dental providers outside of the State of Georgia. | Dental Claims Unit<br><br>MetLife MyBenefits website | 1-866-832-5759<br>TDD 1-800-855-2880<br><br>www.metlife.com/mybenefits |
| **Claim Status** | Dental Claims Unit<br><br>MetLife MyBenefits website (you must register on the site to access claim information) | 1-866-832-5759<br>TDD 1-800-855-2880<br><br>www.metlife.com/mybenefits |
| **For Pre-Determination of Dental Benefits**<br>A member should always seek a pre-determination of dental benefits for any of the following dental services:<br>• If the charges are expected to be $350 or greater;<br>• Orthodontia services;<br>• Prosthetics, crowns, inlays;<br>• Fixed bridgework; or<br>• Periodontal procedures. | Dental Claims Unit | 1-866-832-5759<br>TDD 1-800-855-2880 |
| **HIPAA Coverage** | Secretary | U.S. Dept. of Health and Human Services<br>Office of Civil Rights, Region IV<br>61 Forsyth St. SW, Suite 3B70<br>Atlanta, GA 30303-8909<br>404-562-7886 (metro Atlanta)<br>1-866-627-7748 (outside of metro Atlanta) |

University System of Georgia dental benefits website: http://www.usg.edu/employment/benefits/dental/

# Table of Contents

# BOR Indemnity Dental Benefits
# Plan Summary Document

# Your Indemnity Dental Benefits Plan

## Introduction

This booklet describes the Board of Regents Indemnity Dental Benefits Plan (the plan), available to eligible employees of the University System of Georgia (the System), effective January 1, 2011. When a member retires from active service with the University System of Georgia, participation in the indemnity dental plan may be continued into retirement if the member complies with the requirements as prescribed by the Board of Regents Policy Manual.

The Board of Regents of the University System of Georgia has signed an agreement with Metropolitan Life Insurance Company (MetLife) to access the MetLife Preferred Dentist Program. MetLife will facilitate customer service and claims administration for the plan. The Board of Regents of the University System of Georgia is the plan sponsor for this self-insured, employee-pay-all dental benefits program.

Your indemnity dental benefits plan is designed with two important goals in mind. The primary purpose of the dental plan is to provide you and your family with access to dental care. We strongly encourage plan participants to use network providers to minimize out-of-pocket expenses. When accessing network providers, your dental plan will offset member costs for medically necessary dental treatment that is covered by plan design.

The second goal of the indemnity dental benefits plan is to encourage covered members and their families to take an active role in decisions regarding their dental healthcare. That involvement begins with reading this booklet and with learning how your dental plan works. It is your responsibility to become familiar with the plan's provisions, and, to make efficient use of the coverage provided by the plan. Should you have questions regarding your benefits, as presented in this booklet, please contact your campus Human Resources/Personnel Office, or, the appropriate business associate(s) listed on the inside front cover.

## Benefits at a Glance

Provided for your information is a summary of selected benefits that are available to you and your family under the plan:

| | **Plan Provisions and Benefits** |
|---|---|
| **Annual Deductible Per Covered Member** | $50 |
| **Annual Plan Maximum Per Covered Member** | $1,200 |
| **Lifetime Maximum Orthodontic Benefit Per Covered Member** | $1,000 |
| **Preventive Dental Care**<br>• Dental exam and routine scaling and cleaning of teeth (limited to two instances in any one calendar year);<br>• Topical application of sodium fluoride or stannous fluoride to teeth, every 12 months for covered members under age 19;<br>• Dental X-rays - Full mouth x-rays are limited to one every 60 months. Bitewings are limited to 1 per year for adults and 1 every 6 months for children;<br>• Space maintainers to replace prematurely lost teeth; and<br>• Sealants for permanent teeth (limited to covered dependent children between the ages of 6 years and 18 years, once per tooth every 36 months). | Paid at 100% of network rate; **not subject to deductible.**<br><br>Members who elect to use non-network dental providers **will be subject to balance billing.** |
| **Basic Dental Care**<br>• Fillings to restore diseased or broken teeth (multiple fillings on a single tooth surface will be considered as a single filling).<br>• Extraction of a tooth that is not impacted;<br>• General anesthesia when used in conjunction with oral surgery or other dental treatment, and, determined to be medically necessary;<br>• Injections of antibiotic drugs;<br>• Endodontic treatment, including root canal therapy; and<br>• Periodontal treatment, including gingivectomy, and treatment of other diseases of the gums and tissues of the mouth. | 80% of network rate; **subject to deductible**.<br><br>Members who elect to use non-network dental providers **will be subject to balance billing**. |

| | Plan Provisions and Benefits |
|---|---|
| **Restorative Dental Care**<br>• Inlays, onlays and crowns;<br>• Repairs or recementing of crowns, inlays, bridgework or dentures as well as the relining of denture;<br>• Bridge pontic;<br>• Oral surgery;<br>• Osseous surgery;<br>• Initial installation or addition of full or partial dentures or fixed bridgework, if they are necessary as the result of injured or diseased natural teeth being extracted while covered under this plan;<br>• Replacement or alternation of full or partial dentures or fixed bridgework, if necessary as a result of an accidental injury requiring oral surgery, or oral surgery treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, while covered under the this plan. | 80% of network rate; **subject to deductible**.<br><br>Members who elect to use non-network dental providers **will be subject to balance billing**. |
| • Replacement of full denture, if it is required as the result of structural change within the mouth, and if it is made more than five years after the denture was installed; and<br>• Replacement of a crown, if the replacement is made more than five years after the crown was installed. | 80% of network rate; **subject to deductible. Required waiting period of at least 2 years following enrollment in the plan.**<br><br>Members who elect to use non-network dental providers **will be subject to balance billing.** |
| **Orthodontic Dental Care**<br>• Including orthodontic appliances and treatment received during the orthodontic treatment. Orthodontic dental care will begin after one is covered by the plan.<br>**These services include, but are not limited to:**<br>• Preventive treatment procedures;<br>• Removable or fixed appliance therapy; and<br>• Treatment of transitional and permanent dentition. | 80% of network rate; **subject to deductible. Required waiting period of at least 6 months following enrollment in the plan.**<br><br>Members who elect to use non-network dental providers **will be subject to balance billing.**<br><br>Lifetime benefit limit of $1,000. |

## Who Can Enroll

If you are employed by the University System of Georgia for at least 20 hours per week on a regular basis, you are eligible for coverage under the indemnity dental plan beginning your first day at work. If you are a member of the Corps of Instruction (teaching faculty) under contract on at least a regular half-time basis, you are eligible for coverage beginning the first day of the month in which you are required to be at work.

## How to Enroll

You must complete an indemnity dental benefits plan enrollment form to apply for dental coverage. You may obtain this form from your campus Human Resources/Personnel Office. The completed enrollment form must include the legal names and birth dates of all eligible dependents.

The indemnity dental plan provides four levels of coverage:

| Single | Employee + Child | Employee + Spouse | Family |
|---|---|---|---|
| Employee Only | Employee + Child | Employee + Spouse | Employee + Two or More Dependents (Spouse and/or Children) |

## Dependent Coverage

When an employee elects **"Employee + Child"** coverage, **"Employee + Spouse"** coverage, or **"Family"** coverage, his/her eligible dependents may be covered by the indemnity dental plan. Eligible dependents of an employee include:

- Legal spouse (does not include common law spouse);
- Unmarried, natural and adopted children under age 19; or to age 26, if verification of full-time student status at an accredited school is provided;
- Children who have been placed for adoption in connection with assumption by the person of a legal obligation for the total or partial support of a child in anticipation of the legal adoption of such child;
- Unmarried step-children under age 19 who depend on the employee for support and maintenance and who live with the employee in a normal parent-child relationship; or to age 26, who depend on the employee for support and who can provide written verification of full-time student status at an accredited school;
- Unmarried children for whom, as a result of a legal separation or divorce, the employee is legally responsible, even though they may not live with the employee;
- Children for whom the covered employee is the ***permanent*** legal guardian if:

- A court has named the employee as the child's permanent guardian; ***and***
- The child lives in the employee's home in a normal parent-child relationship; ***and***
- The child is dependent on the employee for support.

- Unmarried, disabled children beyond the age limit if:
  - They are unable to support themselves; ***and***
  - They depend on the employee for support; ***and***
  - The condition existed prior to age 19 (or age 26, if they become incapacitated while a full-time student); ***and***
  - Proof of incapacity is furnished within 30 days of the child's 19th birthday (or age 26, if they become incapacitated while a full-time student).

If you have a dependent(s) employed by the University System of Georgia, and your dependent(s) is participating in any University System of Georgia indemnity dental plan, you ***may not*** cover that dependent(s) under your **"employee + child"**, **"employee + spouse"** or **"family"** coverage.

If your spouse is employed by the University System of Georgia, but he/she does not elect to participate in an available dental plan, you may cover him/her under your **"employee + spouse"** or **"family"** coverage.

If both a husband and wife are benefits-eligible employees of the University System of Georgia, only one may elect to provide coverage for the other spouse and/or dependents.

## When Employee Coverage Begins

If you enroll in indemnity dental coverage on your first day of employment, you will be covered by the plan as of:

- The employment date; or
- The first of the month following your date of employment

As an employee of the University System of Georgia, you have 30 days from your effective date of employment to enroll for coverage in the indemnity dental plan. If you enroll in the indemnity dental plan within 30 days of your employment date, you will be covered by the plan as of:

- The date you enroll; or
- The first of the month following your date of employment.

You will have the opportunity to determine when you wish to have your coverage begin; but, in either instance, you will be required to pay for a full month of coverage.

**PLEASE NOTE:** It is important that you enroll in the indemnity dental plan within 30 days of your initial eligibility date, since the plan is generally only available to new employees and within 30

days of a qualifying change in family circumstance. If you transfer to another University System of Georgia Institution, you will not be granted the opportunity to elect indemnity dental coverage upon your transfer.

If you are absent from work, due to illness or injury, on the date that your indemnity dental plan coverage is to be effective, participation in the plan will begin on the first day that you return to active work. Active work is defined as performing all regular and assigned duties at one's normal and required work location.

## When Dependent Coverage Begins

An eligible dependent will become covered on:

- The first day that he/she becomes eligible; or
- The first of the month following his/her date of eligibility.

You will be required to ensure that your dependents, including newborns, are enrolled under your plan coverage within 30 days following his/her eligibility date. You should contact your campus Human Resources/Personnel Office to convey all appropriate information.

An eligible newborn is covered at birth. A dependent, other than a newborn, which is confined to a hospital or other institution when his/her coverage would normally begin, will be covered upon his/her discharge.

If you enroll your dependents within 30 days following their eligibility date, their coverage will begin on:

- The date you apply for coverage; or
- The first of the month following the date in which you apply for coverage.

You will have the opportunity to determine when you wish to have your dependent's coverage begin; but, in either instance, you will be required to pay for a full month of coverage. It is important that you enroll your dependents within 30 days of their becoming eligible for coverage.

## Adding or Deleting Dependents

When you experience some form of a qualifying event, you will need to contact your campus Human Resources/Personnel Office to complete a change form to add, or, to delete a dependent. Some examples of ***"qualifying events"*** include: (A) a change in employment status for you or your spouse; (B) a change in marital status; and (C) the birth or adoption of a child (including stepchildren and legally placed foster children). *There are other examples of qualifying events.*

Change forms must be completed with your campus Human Resources/Personnel Office within 30 days of a qualifying event. Failure to comply with this time requirement will prohibit you from changing your indemnity dental plan coverage.

## Full-Time Student Verification Process for Dependents Ages 19-25

The contract holder will be required to provide verification of his/her dependent's full-time student status ninety (90) days prior to a dependent reaching his/her nineteenth (19) birthday. The contract holder will be required to submit documentation of full-time student status to the institutional Human Resources/Personnel Office where he/she is employed. Examples of required documentation include ***a student registration schedule, a student enrollment tuition receipt, or a student enrollment confirmation letter from the dependent's school***. To ensure continuous coverage, the contract holder must provide the required documentation to his/her employing institution, prior to his/her dependent attaining age 19.

Upon receipt of the required documentation, the employing institution will make the necessary adjustments to the dependent's healthcare coverage. ***Should a contract holder fail to provide the requisite documentation to his/her employing institution, coverage for the student dependent will be terminated.*** It is the contact holder's responsibility to notify his/her campus Human Resources/Personnel Office when the member, or his/her covered dependent(s), is no longer eligible for University System of Georgia indemnity dental coverage. Such notification is required for the member and his/her covered dependents to be eligible to participate in COBRA dental coverage.

## Full-Time Student Status Change Upon Attainment of Age 26

Your indemnity dental care plan will provide coverage for your full-time student dependent until he/she attains age 26. Upon the dependent's 26th birthday, their indemnity dental coverage will terminate. For information regarding the continuation of dental coverage for your dependent through their COBRA benefits, please see page 25 for section entitled ***Your COBRA Rights***.

## The Cost of Your Dental Coverage

The employee is solely responsible for the cost of the indemnity dental benefit plan. Information regarding employee dental plan contribution rates are shared with your campus Human Resources/Personnel Office. The costs associated with providing this dental plan to employees, retirees, and dependents of the University System of Georgia changes periodically.

Your campus Human Resources/Personnel Office will notify you of any changes in plan costs. Your premium will depend upon the level of coverage (single, employee + child, employee + spouse, or family) that you select. The dental plan premium contribution for active, eligible employees will be paid with ***pre-tax*** dollars.

## Qualifying Events for Changes in Dental Care Plan Coverage

Because your dental premiums are paid with ***pre-tax*** dollars, the Internal Revenue Services (IRS) has established strict rules regarding the operation of your dental plan. A ***qualifying event*** is the only reason that a member may elect to make a change in his/her dental plan coverage.

If you have a qualifying event, you may add, change, or discontinue dental coverage. Appropriate documentation, specific to the qualifying event, must be presented to your campus Human Resources/Personnel Office ***before*** a change in dental plan coverage will be granted or

approved. Some examples of qualifying events include:

- A change in your marital status;
- The birth or adoption of a child (including stepchildren and legally placed foster children);
- The death of a covered dependent;
- A change in the employment status of a covered member, his/her spouse, or his/her covered dependent(s), that affects eligibility for coverage under a cafeteria or other qualified dental plan;
- The loss of eligibility status by a covered dependent;
- A campus approved leave of absence without pay (maximum of 12 months);
- You and/or your spouse being called to full-time active military service/duty;
- Losing ***or*** gaining dental coverage eligibility under Medicare or Medicaid;
- Dental plan election choices made by spouse with different employer in which the employers have different dental plan years (Please see the example below); or
- A court-ordered qualified medical child support order (QMCSO), as explained below

**Example:**

You work for the University System of Georgia (USG) and have a January 1 – December 31 dental benefits plan year. Your spouse works for XYZ employer.

XYZ has an October 1 – September 30 dental benefits plan year. Both employer sponsored dental plans are qualified dental plans.

You have "single" dental coverage with the University System of Georgia. Your spouse, employed by XYZ, discontinues his/her dental coverage with XYZ effective September 30. September 30 is the end of employer XYZ's plan year. You wish to add your spouse, employed by XYZ, under your dental plan with the University System of Georgia, effective October 1. You request to make this change to avoid a break in dental coverage for your spouse.

## Qualified Medical Child Support Order (QMCSO)

A court-ordered qualified medical child support order (QMCSO) results from a divorce, legal separation, annulment, or change in legal custody. A QMCSO requires that you, your spouse, former spouse, or another individual provide healthcare and/or dental coverage for enrolled dependent(s) that have been approved by the court. The court order, and, the effective date of healthcare and/or dental plan coverage for court-designated enrolled dependent(s), must be presented to your campus Human Resources/Personnel Office within 90 days of the court's decision.

PLEASE NOTE: For each of the qualifying events identified above, you must file a timely request with your campus Human Resources/Personnel Office to add or change dental coverage. For instances other than a qualified medical child support order (QMCSO), "timely" means within 30 days of the event that qualified one for a change in healthcare/dental coverage (i.e., employment, loss of coverage, marriage, birth or adoption, etc.) A QMCSO must be presented to your Human Resources/Personnel Office within 90 days of the court's decision.

A failure to complete a change form within 30 days of a qualifying event will prohibit you from making coverage changes in your dental coverage. Unless otherwise noted, the effective date for changes in dental coverage will be the first day of the month following institutional approval.

## The Annual Deductible

The annual deductible is an amount of money that you will be required to pay each plan year (January 1 – December 31) for basic, restorative, and orthodontic covered dental services, before the plan will begin to pay for its portion of covered charges. The annual individual deductible per covered member is $50. ***Member costs incurred for balance billing will not apply toward the annual deductible.***

## The Annual Maximum Plan Benefit

Once you have met your annual deductible, the plan will pay 80% of the network fee for basic and restorative covered dental services, up to an annual maximum benefit of $1,200 per member per plan year. ***Any charges incurred in excess of the annual $1,200 maximum plan benefit will be the responsibility of the member.***

PLEASE NOTE: Certain restorative procedures require the member to be enrolled in the dental plan for a specific period of time before benefit coverage is available. Appropriate waiting periods are referenced throughout this document.

## Maximum Lifetime Benefit

Allowed charges that are incurred by a covered member for ***orthodontic treatment/care*** have a separate lifetime maximum benefit. The maximum ***lifetime dental benefit*** for ***orthodontic treatment/care*** is $1,000 per covered person.

## Pre-Determination of Dental Plan Benefits

Pre-determination of dental plan benefits is recommended by MetLife for treatment plans that involve ***prosthetics, crowns, inlays, onlays, orthodontics, and periodontics.*** If the estimated cost for a recommended dental treatment plan meets or exceeds $350, it is suggested that your dental provider submit a ***pre-determination of dental benefits*** form to the Dental Claims Unit for review, prior to the initiation of member treatment. The Dental Claims Unit will send a notification of covered benefits to you, and to your dental provider, based upon the submitted dental treatment plan. This process ensures that you, and your dental provider, are informed of the member's liability.

If you and your dental provider agree upon a more expensive treatment plan than has been

approved by MetLife, the additional costs will be the responsibility of the member. ***Any charges incurred in excess of the annual $1,200 maximum threshold will be the responsibility of the member.***

Emergency treatments, routine oral examinations, routine dental x-rays, cleaning and scaling, fluoride treatments, and dental services which cost less than $350, does not require a pre-determination of benefits.

## Orthodontic Dental Services

After you satisfy the deductible ***and*** have been enrolled in the plan for a waiting period of 6 months, the plan will pay 80% of the network rate for covered orthodontic dental services. Orthodontic dental services include orthodontic appliances and treatment. ***To receive plan benefits, a member's orthodontic treatment must begin after he/she has enrolled in the Board of Regents indemnity dental plan.***

A course of orthodontic treatment begins when the first orthodontic appliance is installed, and, orthodontic treatment ends when the last appliance is removed. There must be 2 years between courses of treatment; otherwise, successive courses of treatment will be considered as one course of orthodontic treatment.

Your dental provider ***should provide a written pre-determination of dental benefits*** to the Dental Claims Unit. The orthodontic treatment plan will include the findings of your first exam, the recommended treatment strategy, and the associated itemized charges. The orthodontic treatment plan must include the following:

- An itemized listing of orthodontic procedures and associated charges that are required for the correction of a malocclusion; and
- The inclusion of supporting x-rays and appropriate diagnostic materials, as required by the plan.
- Orthodontic benefits will be paid on prorated basis over the length of the course of treatment.
- Please be reminded that there is a separate $1,000 lifetime maximum benefit per person for orthodontic treatment. This lifetime orthodontic treatment maximum is not subject to the $1,200 Annual Plan Maximum.
- There will be no benefits available for orthodontic treatment begun prior to a member enrolling in the Board of Regents indemnity dental plan. Any orthodontic charges incurred in excess of the $1,000 lifetime maximum will be the responsibility of the member.

## Administrative Agents/Business Associates

MetLife is the business associate for the Board of Regents indemnity dental plan.

MetLife will:

- Facilitate customer service;

- Facilitate claims administration services; and

- Provide access to the MetLife Preferred Dentist Program. The MetLife Preferred Dentist Program provides access to network dental providers located within the State of Georgia, as well as, to networkdental providers located outside of the State of Georgia.

# How Your Indemnity Dental Benefits Plan Works

The indemnity dental care plan covers only eligible charges that are:

- ***Medically necessary:*** A service or treatment that, in the judgment of the indemnity dental plan, is both appropriate and consistent with a medical diagnosis. To meet the plan's criteria for medical necessity, any service or treatment must be widely accepted professionally within the United States as effective, appropriate, and essential. The treatment or service must be based on recognized standards of the dental/healthcare specialty involved. The treatment or service may not be experimental in nature; educational; or primarily for research or investigations.

- ***Prescribed by a dental provider.*** A ***dental provider*** for the indemnity dental plan is defined to include a doctor of dental medicine and a doctor of dental surgery. A dental provider must be legally licensed by the Composite Board of the State of Georgia (or a similar board outside of the State of Georgia) to practice dental medicine and/or perform surgery.

  The following professionals are considered to be covered providers under the plan, when acting within the scope of their licenses ***and*** when rendering services as defined by the plan. These professionals would include general dental practitioners, dental surgeons, dental hygienists, orthodontists, periodontists, and endodontists.

- ***Within the dental service network rate:*** A member, who used a MetLife Preferred Dentist Program provider, will be charged only the network rate that has been negotiated by MetLife for dental services. The member will not be subject to balance billing when using a MetLife Preferred Dentist Program provider.

- A plan member who uses an ***out-of-network*** dental provider will be subject to balance billing for any dental charges in excess of the negotiated network rate. ***Please be reminded that member costs incurred for balance billing will not apply toward the annual deductible.***

- ***Covered by the indemnity dental plan:*** There are certain dental treatments, services, and expenses that are not covered by the plan. Such is the case with the University System of Georgia indemnity dental plan. A number of these are identified in this booklet.

## The MetLife Preferred Dentist Program

The MetLife Preferred Dentist Program (PDP) helps reduce your out-of-pocket expenses for covered dental services. Within the PDP, providers throughout the country have contracted to

accept a negotiated rate for covered services rendered.

Dental providers within the PDP have agreed to accept the "allowable charge" as the maximum payment for their services. "Allowable charge" will be based upon the contracted rate that a participating provider has agreed to accept. Each participating provider must agree to accept the indemnity dental plan's established "allowable charge" fee limit as the maximum payment amount for his/her professional services. This means that once you have met your deductible, you will pay for only your appropriate portion of covered dental charges. In addition, a participating provider will prepare and file all of your dental claims for you.

Dental care plan participants, who access the PDP, ***will not*** be subject to balance billing. Failure to access the PDP ***will result*** in the member being subject to balance billing.

It is always your choice to select and use either a participating provider or a non-participating provider. Please be informed that many non-participating providers will not file your dental claims for you. Please, also, be informed that a non-participating provider has not signed an agreement with the PDP to accept the indemnity dental plan's "allowable charge" as the maximum payment amount for his/her professional services. This means that you may be subject to balance billing***. Member costs incurred for balance billing will not apply toward the annual deductible.***

To determine if your dentist is in the PDP, please ask him or her. When visiting a new dentist, or when being referred to a specialist, it is wise to check in advance to see if he/she is a PDP participating provider. Information regarding participating providers may be determined by contacting the Dental Claims Unit customer service telephone number. This telephone number is listed on your indemnity dental plan identification card. You may also determine if your dental provider is a member of the PDP by visiting the MetLife MyBenefits website at www.metlife.com/mybenefits.

## Expenses The Indemnity Dental Plan Does Not Cover (Exclusions)

Some of the dental services, supplies or treatments that are not covered by the indemnity dental plan include, but are not limited to:

- Those that exceed the MetLife Preferred Dentist Program contracted network rates for covered dental charges;
- Those that are not medically necessary;
- Treatment not performed by a dental provider or doctor;
- Those that are provided by an immediate family member or household resident;
- Treatment performed by a licensed dental hygienist who is not supervised by a dental provider;
- Those that were received prior to being eligible for plan participation and coverage;
- Treatment due to injury or illness that is covered under any Workers' Compensation Law, occupational disease law or similar laws;

- Those charges incurred by a member from his/her dental provider for failure to keep a scheduled appointment;
- Those charges incurred for the completion of any forms required for benefits to be paid;
- Services for which you are not required to pay, or, for services in which no charge would have been made in the absence of dental benefits;
- Charges for services or supplies that do not meet accepted standards of dental practice, including charges for services or supplies that are experimental in nature;
- Charges or expenses for procedures, appliances and restorations, other than full dentures used to split or to change vertical dimension or to restore an occlusion;
- Surgical extraction of impacted teeth, but not including partially erupted teeth;
- To replace lost or stolen dentures and/or bridgework;
- The installation, replacement, or alternation of dentures or fixed bridgework, other than those services that are listed under covered services;
- Charges associated with dietary planning for the control of dental cavities, oral hygiene instruction, including plaque control, or training in dental care;
- Charges incurred for which benefits are paid under any public plan of dental insurance for which a covered person is eligible;
- Charges for services or supplies received as a result of dental disease or injury due to an act of war, declared or undeclared, or a warlike act in time of peace;
- A crown, gold restoration, or bridge, if the tooth was prepared before you or your dependent were covered by the plan;
- Root canal therapy if the pulp chamber was opened before you or your dependent were covered by the plan;
- Continuation of orthodontic treatment if the treatment began prior to the member being covered by the plan;
- An appliance, or the alteration of an appliance, if the impression was made before you or your dependent were covered by the plan;
- Charges or conditions for which others are responsible;
- Services or supplies received by a covered person before that individual is eligible for dental benefits;
- Use of materials, other than fluoride, to prevent tooth decay;
- Procedures that are cosmetic in nature (e.g. bleaching, whitening and bonding);

- For training and/or appliance to correct or control harmful habits, including, but not limited to, muscle training therapy (myofunctional therapy);
- Night or occlusional guard appliances;
- Services or supplies that are for cosmetic purposes, unless they are:
    - Otherwise a covered expense and are necessary because of an illness or injury that happened while you are covered or,
    - Required for reconstructive surgery because of a congenital disease or abnormality of a covered dependent that results in a functional defect;
- For prescription or non-prescription drugs, vitamins, or dietary supplements;
- For house or hospital calls for dental services;
- For hospitalization costs;
- For treatment of fractures and dislocations of the jaw;
- Charges for care, treatment, services or supplies to the extent that any benefit is provided by Medicare;
- Charges that were not considered to be a “covered expense”, due to a pre-determination of benefits;
- Charges for nitrous oxide, novocaine, xylociane, or any similar local anesthetic, when the charge is made separately from a covered dental expense;
- For the following that are not included as orthodontic benefits: Retreatment of orthodontic cases, changes in orthodontic treatments necessitated by patient neglect, or repair of an orthodontic appliance; and
- Services or supplies for which benefits are otherwise provided under the plan or any other plan that the System (or an affiliate) contributes to or sponsors.

## When Your Indemnity Dental Plan Coverage Ends

Your coverage, under the indemnity dental plan, will end on the last day of the month in which:

- You are no longer eligible to participate in the plan;
- You elect to withdraw from the plan during an Open Enrollment period;
- Your employment is terminated, except due to death;
- You fail to make any required employee contribution; or
- The indemnity dental plan is terminated.

Please be reminded that you may continue with your coverage under the indemnity dental plan, if you are on a campus-approved leave of absence.

MetLife will issue a ***Certificate of Creditable Coverage*** to a member when his/her indemnity dental plan coverage ends. The ***Certificate of Creditable Coverage*** may be presented to a new employer to demonstrate proof of previous dental plan coverage. The MetLife ***Certificate of Creditable Coverage*** affords compliance with specific provisions of the federal Health Insurance Portability and Accountability Act (HIPAA).

## When Indemnity Dental Plan Coverage for Your Eligible and Covered Dependent(s) Ends

Your indemnity dental plan provides coverage for a full-time student dependent until he/she attains age 26. ***On a dependent's 26th birthday,*** his/her dental care coverage will terminate. Dental coverage extended to your eligible and covered dependents (other than full-time students) will end on the last day of the month in which:

- Your dependent(s) ceases to be eligible;
- You are no longer eligible to participate in the plan;
- Your dependent(s) becomes eligible for coverage under the plan, as a University System of Georgia employee;
- You elect to withdraw from the plan during an Open Enrollment period;
- Your employment is terminated;
- You elect to reduce your level of benefit coverage: (1) from ***"family"*** coverage to ***"employee + child"*** or ***"employee + spouse"*** or ***"single"*** coverage; or (2) from ***"employee + child"*** or ***"employee + spouse"*** to ***"single"*** coverage;
- You fail to make your required employee premium payment; or
- The plan is terminated.

If your indemnity dental plan coverage ends, you and/or your dependents may be eligible for an extension of coverage under the special provisions of the plan. Please see the sections entitled, "Coverage After Retirement" or "Extended Coverage for Your Dependents After Your Death".

## Coverage After Retirement

When a member retires from active service with the University System of Georgia, participation in the indemnity dental plan may be continued into retirement if the member complies with the requirements as prescribed by the Board of Regents ***Policy Manual***. A member who enters retirement may continue with the same level of dental coverage that he/she had immediately prior to retirement.

Please be reminded that once a member has entered retirement, the member will not be

permitted to add dental coverage or to increase the level of coverage that he/she carried into retirement.

Continued participation in the indemnity dental plan is voluntary. The cost for dental benefit coverage will be the sole responsibility of the employee/retiree. Dental plan premiums change periodically. Your campus Human Resources/Personnel Office will notify you of any changes in your member premium costs.

If you carry ***"employee + child"***, ***"employee + spouse"***, or ***"family"*** dental coverage into retirement and you predecease your spouse, your covered dependents will be permitted to continue their dental coverage. Dental coverage for the surviving spouse of a contract holder will continue until the surviving spouse's death or remarriage. Coverage for dependent children will continue until they cease to be eligible. The dental premiums for a surviving spouse, or for other covered dependents, will be adjusted to the appropriate level of coverage.

Only covered members who retire from the University System of Georgia, on or after January 1, 1994, will be eligible to carry indemnity dental benefits into retirement.

## Extended Dental Coverage for Dependents After the Death of a Covered Employee

(A) Deceased University System of Georgia Employee With A Minimum of Ten Years of Service

A dependent, of an active employee who dies while in active service or in retirement, may remain as a participant of the indemnity dental plan under the following conditions:

- The deceased employee must have had at least ten years of continuous service in a benefits eligible position with the University System of Georgia; or

- The deceased employee must have had ten years of continuous service with the State of Georgia. The final two years of State of Georgia continuous service must have been with the University System of Georgia in a benefits eligible position.

The University System of Georgia will continue to allow a dependent(s) to continue to participate in the indemnity dental plan until he/she ceases to be eligible. Dental coverage for a deceased member's spouse will continue until the surviving spouse's death or remarriage.

(B) Deceased University System of Georgia Employee With Less Than Ten Years of Service

A dependent, of an active employee who dies with less than ten years of service, may remain as a participant in the indemnity dental plan for no more than 24 consecutive months after the death of the employee. After the 24-month period, one may elect to continue with dental coverage through utilization of COBRA benefits. Please see the section entitled, ***"Your COBRA Rights"***, located on page 25 of this booklet.

## Claim Filing Limit

Whether you receive dental care from a provider who is or is not a member of the MetLife Preferred Dentist Program, you will have one year from the date that such service was rendered to file a claim and receive reimbursement for covered charges. All dental claims should be submitted to:

MetLife Dental Claims
P.O. Box 14588
Lexington, KY 40512

Claim forms for dental services are available and may be obtained from your campus Human Resource/Personnel Office, from the Dental Claims Unit, the MetLife MyBenefits website, www.metlife.com/mybenefits, or, via the University System of Georgia website, http://www.usg.edu/employment/benefits/dental/. You may download an electronic version of the dental claim form from either website address.

## General Information Required to File a Claim

To process your dental claim, the following information is required regardless of the provider. Plan benefits will be paid upon receipt of: (1) a completed claim form; and (2) provider documentation of medical treatment and/or services. The claim form must be completed in its entirety. Any missing information may cause a delay in the processing of your reimbursement. The following information must be included on the claim form:

- Name of the contract holder; contract number; and group number, exactly as it appears on your member identification card;
- Provider documentation of medical treatment/services and detailed diagnosis; and
- A copy of the provider's billing statement indicating:
  - The name of the patient;
  - The type of treatment or services rendered;
  - The date and charges for treatment or services; and
  - The signature of the provider.

Please retain a copy of all claim forms and bills for your records.

PLEASE NOTE: The following do not meet the supporting documentation requirements for filing a paper claim: (1) a provider billing statement that reflects a "balance due" amount; (2) a cash receipt issued to a member from a provider; and/or (3) a canceled check reflecting a member's payment for provider services.

## Filing Paper Claims/Foreign Claims While Traveling Abroad

If a member receives dental care while traveling outside of the United States, he/she will be required to pay the provider at the time that dental services are rendered. The member will have one year from the date that the dental services were rendered to file a paper claim and receive reimbursement for covered charges. Claims should be submitted to:

MetLife Dental Claims
P.O. Box 14588
Lexington, KY 40512

Plan benefits will be paid upon receipt of: (1) a completed claim form; and (2) an itemized bill for medical treatment and/or services. The member will be required to have the itemized bill translated into English prior to submitting a paper claim to the Dental Claims Unit. To expedite the processing of such claims, the billed amount should be converted to an equivalent United States currency rate.

The claim form must be filled out in its entirety. Any missing information may cause a delay in processing your reimbursement.

PLEASE NOTE: An explanation of benefit (EOB) form and reimbursement for covered dental treatment/services will be mailed to a member's United States mailing address. MetLife will not mail this type of information to any address outside of the United States.

Please be reminded that the member must pay for provider services rendered outside of the United States. MetLife will not reimburse a non-United States dental provider.

## Denial of a Dental Claim by MetLife

If a member has a dental claim that is denied by MetLife, he/she will receive written notification from the Dental Claims Unit. The denial notice will include:

- The specific reason(s) for the denial;
- A reference to the plan provision(s) that supports the denial by MetLife;
- A clarification of the information required from the member/provider to complete the processing of the claim; and
- An explanation regarding the necessity for providing additional information.

If a time extension to process a claim is required by MetLife, the member will be notified in writing and provided with an explanation for the reason for the extension.

## Appealing a Denied Claim

A member has a right to express concerns about a denied claim and to expect an unbiased resolution of his/her issues. The Dental Claims Unit is an important informational resource that should be initially contacted to answer member inquiries and to confirm the types of coverage

that have been adopted/implemented for the indemnity dental plan.

If a dental claim is denied, the member may appeal this decision to the Dental Claims Unit ***within 60 days*** of the date that the claim was denied.

Please contact the Dental Claims Unit at 1-866-832-5759 / TDD 1-800-855-2880. Please share your concerns regarding a denied dental claim with the Dental Claims Unit customer service representative. When discussing a claim, please provide the following information:

- Contract holder name and identification number;
- Patient name and address;
- Provider name and address (dental provider);
- Date/dates of service; and
- Type of service received.

You have the right to submit a written inquiry regarding your denied dental claim. Written inquiries should be directed to:

MetLife Dental Claims
P.O. Box 14588
Lexington, KY 40512

You should receive a written response from the Dental Claims Unit regarding your initial written inquiry within 60 calendar days.

Following the review process by the Dental Claims Unit, a member may submit a final appeal to the plan administrator. The plan administrator will not accept any member appeal until the entire Dental Claims Unit process has been completed. The member will be required to provide the plan administrator with all supporting documentation presented at the respective levels of the Dental Claims Unit appeal process. The plan administrator will render a final decision.

## Assignment of Benefits

The process of assignment of benefits permits a member to have his/her plan benefits paid directly to a provider for dental treatment/services that have been rendered. Dental benefits are automatically paid to dental providers that participate in the MetLife Preferred Dentist Program.

## Subrogation

The indemnity dental plan includes a subrogation clause. If a covered member incurs dental expenses for an injury or illness involving alleged negligence/misconduct of another party, MetLife may have a claim against the other party for payment of a covered member's dental bills. MetLife can seek to recover the cost of a member's dental treatment/services incurred by the plan for such expenses. MetLife can seek recovery of associated dental costs from either the member or from a third party. The member will be responsible for providing MetLife with any

information or assistance needed to enforce this provision.

# Administrative Information

## Coordination of Benefits (COB)

A number of dental plan members and enrolled dependents may be covered under another dental plan that provides dental benefits on a group-insurance basis. If you are such a member, you should be informed about the indemnity plan's provision for "Coordination of Benefits (COB)".

The indemnity plan's COB provision stipulates that, when there is multiple coverage by two or more group-insurance dental benefit plans, reimbursement by the Board of Regents indemnity plan will not exceed 100% of the covered charges incurred. Covered charges do not include member penalties assessed for plan non-compliance.

The COB provision applies to any group-insurance dental benefit plan. Examples would include governmental programs, such as Medicare; or the employer of a spouse who offers group-insurance dental benefits. COB does not apply to an individual policy for dental coverage for which the member pays the total premium directly to the insurer.

To administer the COB provision, it must be determined which group-insurance dental plan is deemed to have "primary" coverage. The primary plan will be required to initially process and pay any covered dental claims. This generally means that the primary plan will pay for the majority of the costs associated with such claims. Any other group-insurance dental plan(s) is deemed to have "secondary" coverage responsibilities.

The decision regarding which group-insurance dental plan is "primary", is made as follows:

1) A plan without a Coordination of Benefits (COB) provision is primary over a plan with COB provision.
2) A group-insurance dental plan that covers an individual as an active or retired employee is primary over a group-insurance dental plan that covers an individual as a dependent.
3) For children, the dental plan of the parent whose birthday occurs earlier in the calendar year is deemed to be primary. If both parents' birthdays occur on the same day, the dental plan that has insured the parent for the longest period of time is primary. If one of the plans does not have the parent birthday rule, the father's dental plan is primary.
4) For children of separated or divorced parents:
    a) When a court decree has determined that one parent has financial responsibility for medical, dental or other healthcare expenses of a child, the dental plan of the parent with court-decreed financial responsibility is primary to any other plan covering the child (regardless of which parent has custody).
    b) When a court decree states that the parents will share joint custody, without specifying which parent has financial responsibilities for medical or dental care expenses of a child, the plan providing primary coverage for the child, will follow the sequence of benefit determination rules presented below:

i. The dental plan of the parent whose birthday occurs earlier in the calendar year is primary;

ii. When both parents' birthdays occurs on the same day, the dental plan that has insured the parent for the longest period of time is primary; and

iii. If one of the plans does not have the parent birthday rule, the father's dental plan is primary.

c) In the *absence of court-decreed financial responsibility:*

i. For dental plans that cover a *child of separated or divorced parents who have not remarried*, the dental plan of the parent with custody is deemed to be primary.

ii. For dental plans that cover a child of remarried parent(s):

(1) The dental plan of the remarried parent, with custody, is deemed to be primary;

(2) The dental plan of the step-parent is deemed to be secondary; and

(3) The dental plan of the biological parent, without custody, is deemed to have the third level of dental care payment responsibility.

5) The dental plan that covers an insured individual as an active employee is primary over a dental plan that covers a retiree, or, a laid-off employee. The same process is true for an active employee covered by his/her employer's group-insurance dental plan who is also covered as a dependent under a retiree's/laid-off employee's group-insurance dental plan. An active employee's dental plan will have primary coverage responsibilities.

Benefits under the Board of Regents indemnity dental plan will be coordinated with dental benefits provided by the federal Medicare program, if appropriate.

If you return to active employment with another employer after you reach age 65 ***and*** you are covered by the new employer's group-insurance dental plan, then: (1) your new employer's dental plan will be primary; and (2) the Board of Regents dental plan will serve as secondary.

## Your Cobra Rights

Under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), you or your covered dependents have the option of continuing dental coverage under the Board of Regents indemnity dental plan. Terms, conditions, and costs for dental coverage are identified below. You will be required to comply with all plan requirements to receive covered benefits.

You may elect COBRA coverage under the following conditions:

- Coverage for you and your covered dependents can be continued for up to 18 months if:
  - You terminate your employment with the University System of Georgia, for reasons other than gross misconduct; or
  - You have a reduction in your work commitment to less than half time. To be eligible for

benefits coverage, you must be employed by the University System of Georgia for at least 20 hours per week on a regular basis.

- There are changes in family circumstances that would permit a covered dependent to extend his/her COBRA coverage from an initial 18-month eligibility period up to a maximum of a 36-month eligibility period. Presented below are the conditions that would permit this extension of COBRA healthcare coverage for up to 36 months.
  - Coverage may be provided for your spouse and dependents, if you die;
  - Coverage may be provided for your spouse and dependents, if you legally separate or divorce; or
  - Coverage may be provided for your child, when the child is no longer an eligible dependent under the indemnity dental plan.
- Under certain conditions, COBRA dental coverage may be granted for a period of 29 months:
  - A covered member of your family is disabled at the time of the loss of your dental coverage.
- Under certain conditions, COBRA dental coverage may be extended from an initial 18 month eligibility period to a 29-month eligibility period:
  - A covered member of your family becomes disabled while you are receiving COBRA dental benefits.

If the indemnity dental plan continues to provide coverage for any period of time after a COBRA qualifying event occurs, such time will be counted against the 18, 29, or 36 months of COBRA eligibility.

The cost for COBRA dental coverage will be the responsibility of the employee. An employee will also be responsible for the payment of an additional 2% administrative fee. A member's cost for COBRA dental coverage would, therefore, be 102% of the total indemnity dental premiums. The employee premium costs for the indemnity dental plan changes periodically. As changes in premiums for the indemnity plan change, costs for COBRA dental coverage will change accordingly.

COBRA dental premiums must be paid to your campus Human Resources/Personnel Office. A member must make an election for COBRA dental coverage within 60 days of his/her loss of University System of Georgia dental coverage.

The member must submit his/her initial premium payment within 45 days of election of COBRA coverage or COBRA dental continuation rights will be forfeited. ***A member will be required to remit all premiums to his/her institution from the date of his/her initial loss of Board of Regents dental coverage.***

Thereafter, the member will be responsible for remitting monthly premiums to his/her campus Human Resources/Personnel Office, consistent with an institutionally determined schedule of

payment.

PLEASE NOTE: It is the member's responsibility to notify his/her campus Human Resources/Personnel Office when the member or his/her covered dependent(s) are no longer eligible for Board of Regents dental coverage. Such notification is required for the member and his/her covered dependents to be eligible to participate in COBRA dental coverage.

It is also the member's responsibility to notify his/her campus Human Resources/Personnel Office when there is a change in the member's or in the member's covered dependents' COBRA eligibility status.

COBRA dental coverage will end prior to the end of the 18-month, 29-month or 36-month maximum eligibility participation period if:

- A COBRA-covered disabled family member who recovers from his/her disability after the initial 18-month eligibility period and prior to the conclusion of the 29-month COBRA eligibility period;

- The member fails to remit his/her required COBRA dental premium within the institutionally approved schedule for payment; or

- The Board of Regents indemnity dental plan is terminated.

# Health Insurance Portability and Accountability Act (HIPAA)

## Notice of Privacy Practices

The broad mission and extensive scope of operations of the Board of Regents of the University System of Georgia, including the constituent colleges and universities of the University System of Georgia (collectively, the "Board"), necessitates that the Board collect, maintain, and, where necessary, disseminate health information regarding the Board's students, employees, volunteers, and others. For example, the Board collects medical information through its various medical and dental hospitals, clinics, and infirmaries; through the administration of its various medical and life insurance programs; and through its various environmental health and safety programs. The Board protects the confidentiality of individually identifiable health information that is in its possession. Such health information, which is protected from unauthorized disclosure by Board policies and by state and federal law, is referred to as "protected health information," or "PHI."

PHI is defined as any individually identifiable health information regarding the medical/dental history, the mental or physical condition, or the medical treatment of an employee, a student, or a patient. Examples of PHI include patient name, address, telephone and/or fax number, electronic mail address, social security number or other patient identification number, date of birth, date of treatment, medical treatment records, medical enrollment records, or medical claims records. The Board will follow the practices that are described in its Notice of Privacy Practices ("Notice"). The Board reserves the right to change the terms of its Notice and of its privacy policies, and to make the new terms applicable to all PHI that it maintains. Before the Board makes an important change to its privacy policies, it will promptly revise its Notice and post a new Notice in conspicuous locations

## Permitted Uses and Disclosures of PHI

The following categories describe the different ways in which the Board may use or disclose your PHI. We include some examples that should help you better understand each category. The Board may receive, use, or disclose your PHI to administer your health and dental benefits plan. Please be informed that the Board, under certain conditions and circumstances, may use or disclose your PHI without obtaining your prior written authorization. An example of this would be when the Board is required to do so by law.

- ***For Treatment.*** The Board may use and disclose PHI as it relates to the provision, coordination, or management of medical treatment that you receive. The disclosure of PHI may be shared among the respective healthcare/dental providers who are involved with your treatment and medical/dental care. For example, if your primary care physician/dental provider needs to use/disclose your PHI to a specialist, with whom he/she consults regarding your condition, this would be permitted.

- ***For Payment.*** The Board may use and disclose PHI to bill and collect payment for healthcare/dental services and items that you receive. The Board may transmit PHI to verify that you are eligible for healthcare and/or dental benefits. The Board may be required to

disclose PHI to its business associates, such as its claims processing vendor, to assist in the processing of your health and dental claims. The Board may disclose PHI to other healthcare/dental providers and health/dental plans for the payment of services that are rendered to you or to your covered family members by such providers or health/dental plans.

- ***For Healthcare Operations.*** The Board may use and disclose PHI as part of its business operations. As an example, the Board may require a healthcare/dental vendor partner (referred to as a "business associate") to survey and assess constituent satisfaction with healthcare/dental plan design/coverage. Constituent survey results assist the Board in evaluating quality of care issues and in identifying areas for needed healthcare/dental plan improvements. Business associates are required to agree to protect the confidentiality of your individually identifiable health information.

  The Board may disclose PHI to ensure compliance with applicable laws. The Board may disclose PHI to healthcare/dental providers and health/dental plans to assist them with their required credentialing and peer review activities. The Board may disclose PHI to assist in the detection of healthcare/dental care fraud and abuse. Please be reminded that the lists of examples that are provided are not intended to be either exhaustive, or exclusive.

- ***As Required by Law and Law Enforcement.*** The Board must disclose PHI when required to do so by applicable law. The Board must disclose PHI when ordered to do so in a judicial or administrative proceeding. The Board must disclose PHI to assist law enforcement personnel with the identification/location of a suspect, fugitive, material witness, or missing person. The Board must disclose PHI to comply with a law enforcement search warrant, a coroner's request for information during his/her investigation, or for other law enforcement purposes.

- ***For Public Health Activities and Public Health Risks.*** The Board may disclose PHI to government agencies that are responsible for public health activities and to government agencies that are responsible for minimizing exposure to public health risks. The Board may disclose PHI to government agencies that maintain vital records, such as births and deaths. Additional examples in which the Board may disclose PHI, as it relates to public health activities, include assisting in the prevention and control of disease; reporting incidents of child abuse or neglect; reporting incidents of abuse, neglect, or domestic violence; reporting reactions to medications or product defects; notifying an individual who may have been exposed to a communicable disease; or, notifying an individual who may be at risk of contracting or spreading a disease or condition.

- ***For Health Oversight Activities.*** The Board may disclose PHI to a government agency that is authorized by law to conduct health oversight activities. Examples in which the Board may disclose PHI, as it relates to health oversight activities, include assisting with audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities that are necessary to monitor healthcare systems, government programs, and compliance with civil rights laws.

- ***Coroners, Medical Examiners, and Funeral Directors.*** The Board may disclose PHI to coroners, medical examiners, and funeral directors for the purpose of identifying a decedent; for determining a cause of death; or, otherwise as necessary, to enable these parties to carry out their duties consistent with applicable law.

- ***Organ, Eye, and Tissue Donation.*** The Board may release PHI to organ procurement organizations to facilitate organ, eye, and tissue donation and transplantation.

- ***Research.*** Under certain circumstances, the Board may use and disclose PHI for medical research purposes.

- ***To Avoid a Serious Threat to Health or Safety.*** The Board may use and disclose PHI to law enforcement personnel or other appropriate persons. The Board may use and disclose PHI to prevent or lessen a serious threat to the health or safety of a person or the public.

- ***Specialized Government Functions.*** The Board may use and disclose PHI for military personnel and veterans, under certain conditions, and if required by the appropriate authorities. The Board may use and disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities. The Board may use and disclose PHI for the provision of protective services for the President of the United States, other authorized persons, or foreign heads of state. The Board may use and disclose PHI to conduct special investigations.

- ***Workers' Compensation.*** The Board may disclose PHI for worker's compensation and similar programs. These programs provide benefits for work-related injuries or illnesses.

- ***Appointment Reminders/Health Related Benefits and Services.*** The Board and/or its business associates may use and disclose your PHI to various other business associates that may contact you to remind you of a healthcare or dental appointment. The Board may use and disclose your PHI to business associates that will inform you of treatment program options, or, of other health related benefits/services such as disease state management programs.

- ***Disclosures for HIPAA Compliance Investigations.*** The Board must disclose your PHI to the Secretary of the United States Department of Health and Human Services (the "Secretary") when so requested. The Secretary may make such a request of the Board to investigate its compliance with privacy regulations of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

## Uses and Disclosures of Your PHI to Which You Have an Opportunity to Object

You have the opportunity to object to certain categories of uses and disclosures of PHI that the Board may make:

- ***Patient Directories.*** Unless you object, the Board may use some of your PHI to maintain a directory of individuals in its hospitals or provider facilities. This information may include your name, your location in the facility, your general condition (e.g. fair, stable, etc.), and your religious affiliation. Religious affiliation may be disclosed to members of the clergy. Except for religious affiliation, the information that is maintained in a patient directory may be disclosed to other persons who request such information by referring to your name.

- ***Disclosures to Individuals Involved in Your Health Care or Payment for Your Health Care.*** Unless you object, the Board may disclose your PHI to a family member, another

relative, a friend, or another person whom you have identified as being involved with your healthcare, or, responsible for the payment of your healthcare/dental care. The Board may also notify these individuals concerning your location or condition.

- ***Fundraising Activities.*** Unless you object, the Board may disclose your PHI to contact you for fundraising efforts to support the Board, its related foundations, and/or its cooperative organizations.

  Such disclosure would be limited to personal contact information, such as your name, address and telephone number. The money raised in connection with these fundraising activities would be used to expand and support the provision of healthcare and related services to the community.

If you object to the use of your PHI in any, or all, of the three instances identified above, please notify your campus or facility privacy officer, in writing.

## Other Uses and Disclosures of Your PHI for Which Authorization Is Required

Certain uses and disclosures of your PHI will be made only with your written authorization. Please be advised that there are some limitations with regard to your right to object to a decision to use or disclose your PHI.

**Regulatory Requirements**. The Board is required, by law, to maintain the privacy of your PHI, to provide individuals with notice of the Board's legal duties and PHI privacy practices, and to abide by the terms described in this Notice. The Board reserves the right to change the terms of its Notice and of its privacy policies, and to make the new terms applicable to all PHI that it maintains. Before the Board makes an important change to its privacy policies, it will promptly revise its Notice and post a new Notice in conspicuous locations. You have the following rights regarding your PHI:

- You may request that the Board restrict the use and disclosure of your PHI. The Board is not required to agree to any restrictions that you request, but if the Board does so, it will be bound by the restrictions to which it agrees, except in emergency situations.

- You have the right to request that communications of PHI to you from the Board be made by a particular means or at particular locations. For instance, you might request that communications be made at your work address, or by electronic mail, rather than by regular US postal mail. Your request must be made in writing. Your request must be sent to the privacy officer on your campus or facility. The Board will accommodate your reasonable requests without requiring you to provide a reason for your request.

- Generally, you have the right to inspect and copy your PHI that the Board maintains, provided that you make your request in writing to the privacy officer on your campus or your facility. Within thirty (30) days of receiving your request (unless extended by an additional thirty (30) days), the Board will inform you of the extent to which your request has, or, has not been granted. In some cases, the Board may provide you with a summary of the PHI that you request, if you agree in advance to a summary of such information and to any associated

fees. If you request copies of your PHI, or agree to a summary of your PHI, the Board may impose a reasonable fee to cover copying, postage, and related costs.

- If the Board denies access to your PHI, it will explain the basis for the denial. The Board will explain your opportunity to have your request and the denial reviewed by a licensed healthcare professional (who was not involved in the initial denial decision).

- This healthcare/dental care professional will be designated as a reviewing official. If the Board does not maintain the PHI that you request, but it knows where your requested PHI is located; it will advise you how to redirect your request.

- If you believe that your PHI maintained by the Board contains an error or needs to be updated, you have the right to request that the Board correct or supplement your PHI. Your request must be made in writing to the privacy officer on your campus or in your facility. Your written request must explain why you desire an amendment to your PHI.

- Within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), the Board will inform you of the extent to which your request has, or, has not been granted. The Board generally can deny your request, if your request for PHI: (i) is not created by the Board, (ii) is not part of the records the Board maintains, (iii) is not subject to being inspected by you, or (iv) is accurate and complete.

- If your request is denied, the Board will provide you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial, (ii) if you do not file a statement of disagreement, to submit a request that any future disclosures of the relevant PHI be made with a copy of your request and the Board's denial attached, and (iii) complain about the denial.

- You generally have the right to request and receive a list of the disclosures of your PHI that the Board has made at any time during the six (6) years prior to the date of your request (provided that such a list would not include disclosures made prior to April 14, 2003).

- The list will not include disclosure for which you have provided a written authorization, and will not include certain uses and disclosures to which this Notice already applies, such as those: (i) for treatment, payment, and health/dental care operations, (ii) made to you, (iii) for the Board's patient directory or to persons involved in your healthcare/dental care, (iv) for national security or intelligence purposes, or (v) to correctional institutions or law enforcement officials.

- You should submit any such request to the privacy officer on your campus or in your facility. Within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), the Board will respond to you regarding the status of your request. The Board will provide the list to you at no charge. If you, however, make more than one request in a year, you will be charged a fee for each additional request. You have the right to receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically. This notice may be found at the Board website address, www.usg.edu/legal/. To obtain a paper copy of this notice, please contact your campus or facility privacy officer.

- You may complain to the Board if you believe your privacy rights, with respect to your PHI,

have been violated by contacting the privacy officer on your campus or in your facility. Your must submit a written complaint. The Board will in no manner penalize you or retaliate against you for filing a complaint regarding the Board's privacy practices. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services. You may contact the Secretary by calling 1-866-627-7748 (outside of metropolitan Atlanta) or (404) 562-7886 (in metropolitan Atlanta).

If you have any questions about this notice, please contact the Human Resources office on your campus or in your facility. For additional information, please contact the privacy officer on your campus or facility. Effective Date: April 14, 2003

PLEASE NOTE: On the following page you will find the CONSENT FOR AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION form. This form provides a spouse or another person/class of persons (organization) with the authority to act on behalf of another member. A signed authorization form provides access to PHI (protected health information) for an individual/organization other than the contract holder.

Should you need to access PHI for another individual, we ask that you photocopy this form and submit the completed form to your campus Human Resource/Personnel Office. Your institutional Human Resource/Personnel Office will forward a copy to the vendor (Business Associate/Agent) associated with your request.

Should you have any questions regarding the use of this form, please contact your campus Human Resource/Personnel Office for assistance.

# Consent for Authorization for Use/Release of Health Information

This authorization form applies only to the release and disclosure of protected health information (PHI). This authorization is not for treatment or intended for any other purpose.

By signing this form, I authorize my college, my university, my facility, or the University System office and Business Associates/Agents to use, release, or disclose the protected health information described below to:

Name and address of person/organization to whom information may be sent:

_____.

Transmit this information on or about (information will not be resent absent reauthorization): ___/___/___.

This authorization expires upon fulfillment of this request unless special circumstances apply.

Purpose for disclosure:_____.

I authorize the following information to be sent to the address above:

____ Copies of all medical/dental records for the period ___/___/___ to ___/___/___.

____ Copies of information described below for period ___/___/___ to ___/___/___.

____ History and Physical Examination ____ Lab Reports ____ Reports From Physicians

____ Other (specify) _____.

I understand that this information may include any history of acquired immunodeficiency (AIDS); sexually transmitted diseases (STD); human immunodeficiency virus (HIV) infection; behavioral health services/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

Please include on a separate piece of paper any other special instructions or limitations.

I understand that there may be information in these records that I would not wish to be released. I have been provided with a copy of my college, university, facility, or University System policies and procedures for HIPAA Compliance and any changes thereto which may be associated with this authorization. I have been provided an opportunity to discuss any concerns I may have about the use or misuse of my health information with my institutional or facility privacy officer or other appropriate personnel.

I understand that my institution or facility, the University System of Georgia, or the Board of Regents of the University System of Georgia assumes no responsibility for the use or misuse by others of my health/dental information disclosed under this authorization. I release the Board of Regents of the University System of Georgia and its agents and employees from all legal liability that may arise from this authorization.

Name (please print): _____

Address:_____

Telephone: (____)_____ Fax: (____)_____

Group No.: _____ Group Name:_____

Member ID Number: _____ Social Security Number:_____

Signed:_____

Date of Birth:_____

Date this Authorization Executed:_____

If the signature above is not that of the person whose medical/dental records are authorized to be released, I am acting for the person whose medical/dental records are being authorized for release:

My relationship to such person is:_____

Signed:_____

The person whose medical records are hereby authorized for release or that person's representative may revoke this authorization by notifying in writing the privacy officer at the person's university, college or facility. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is otherwise prohibited by the Health Insurance Portability and Accountability Act of 1996. Federal law also requires a statement that there is a potential for the protected health information released under this authorization to be subject to redisclosure by the recipient.

FORM CREATED 29 JAN 03

# Future of the Plan

The Board of Regents of the University System of Georgia is the plan sponsor for the self-insured indemnity dental plan. While the University System of Georgia expects the indemnity dental plan to remain in effect, the University System of Georgia reserves the right to change the plan, or any benefit under the plan, from time to time; or to discontinue the plan, or any benefit under the plan, at any time.

# Employment Rights Not Implied

Your participation in the indemnity dental plan is not a contract of employment -it does not guarantee you continued employment with the University System of Georgia. Nor does it limit the University System of Georgia's right to discharge you, without regard to the effect that your discharge would have on your rights under the indemnity dental plan. If you quit or if you are discharged, you have no right to future benefits from the plan except as specifically provided in this booklet and the benefit plan document.

# Glossary of Terms

This section of your dental plan booklet provides terminology and phrases used throughout this document.

**Balance Billing**
The dollar amount charged by a provider that is in excess of the plan's allowed amount for medical/dental care or treatment. Amounts that are balance billed by a provider are the member's responsibility. ***Member costs incurred for balance billing will not apply toward the annual deductible.***

**Coinsurance**
Coinsurance is the portion of the covered allowed charges that a member must pay, after he/she has met the appropriate deductible. If a dental plan covers 80% of the cost for a particular benefit, the member would be responsible for the remaining 20% of covered charges. The 20% of allowed charges, paid by the member, is deemed to be the coinsurance amount.

**Contract Year**
A period of one year commencing on the effective date (or renewal date) of a dental plan contract and ending at 12:00 midnight on the last day of the one year period. The contract year for the University System of Georgia begins on January 1 and concludes on December 31.

**Covered Charges**
The portion of a member's billed charges for dental treatment, services, or supplies that will be reimbursed by the dental plan.

**Deductible**
A deductible is a fixed dollar amount that a member must pay out-of-pocket, each plan year, before the dental plan will begin to pay for basic, restorative, or orthodontic covered benefits.

**Dental Hygienist**
A dental hygienist is someone who is currently licensed to practice dental hygiene and is acting under the supervision and direction of a Dentist (Dental Provider).

**Dentist**
A dentist is someone who is currently licensed to practice dentistry and/or oral surgery and acting within the scope of his or her license. The term dentist includes any other doctor who is licensed to provide dental services in the jurisdiction where the service is performed.

**Emergency Care**
Emergency Care means a dental emergency or palliative treatment, for the diagnosis and treatment of pain and/or injury limited to stabilizing the patient's condition. This is an acute condition occurring suddenly and unexpectedly, which usually includes, pain, swelling or bleeding, and demands immediate professional dental services.

**Explanation of Benefits (EOB)**
An Explanation of Benefits (EOB) is an itemized statement of member-incurred dental charges. An EOB will identify paid or denied provider charges following the processing of a filed dental

claim.

**Indemnity Dental Plan**
An indemnity plan is a type of dental plan that provides preventative, routine and major restorative as well as orthodontic dental coverage. This type of dental plan allows a member the greatest flexibility in the selection of dental providers. The current claims administrator for the University System of Georgia's indemnity dental plan is MetLife.

**Medically Necessary**
A service or treatment, which in the judgment of the indemnity dental plan, is both appropriate and consistent with a medical diagnosis. To meet the plan's criteria for medical necessity, any service or treatment must be widely accepted professionally within the United States as effective, appropriate, and essential. The treatment or service must be based on recognized standards of the healthcare/dental specialty involved. The medically necessary treatment or service may not be experimental in nature; educational; or primarily for research or investigations.

**Non-Covered Charges**
Services that are not covered by the indemnity dental benefit plan design.

**Negotiated Rate**
This is the rate of payment the MetLife Preferred Dentist Program has negotiated with Participating Dentists for covered services.

**Non-Participating Dentist**
A Non-Participating Dentist has not signed an agreement with the MetLife Preferred Dentist Program to accept the indemnity dental plan's "allowable charge" as the maximum payment amount for his/her professional services.

**Orthodontic Treatment**
Orthodontic treatment means the corrective movement of teeth through bone by means of an active appliance to correct a malocclusion of the mouth. A pre-determination of dental benefits must be submitted by the dental provider to the plan administrator prior to the beginning of orthodontic treatment. This treatment plan must include the following:

- An itemized listing of orthodontic procedures and associated charges that are required for the correction of a malocclusion; and

- The inclusion of supporting x-rays and appropriate diagnostic materials, as required by the plan.

**Participating Dentist**
This is a dental care provider, designed as such by the MetLife Preferred Dentist Program, who has agreed to provide dental services or supplies at a negotiated rate.

**Pre-Determination of Dental Benefits**
This is a planned program or service of dental care provided to a covered member by one or more dentists over a specified length of time. This includes the dentist's diagnosis of the

patient's dental condition and proposed course of dental treatment. A pre-determination of dental plan benefits is recommend by MetLife for treatment plans involving prosthetics, crowns, inlays, onlays, orthodontics, and periodontics. Whenever the estimated cost of a recommended dental treatment plan exceeds, $350, it is suggested that a pre-determination of dental benefits be submitted to the Dental Claims Unit for its review before treatment begins. The Dental Claims Unit will estimate the benefits payable for that course of treatment and send notification to both the dental provider and the member.

**PHI (Personal Health Information)**

Personal health information, which is protected from unauthorized disclosure by Board of Regents, by state statute, and by federal law, is referred to as "protected health information," or "PHI." PHI is defined as any individually identifiable health information regarding the medical/dental history, the mental or physical condition, or the medical treatment of an employee, a student, or a patient. Examples of PHI include patient name, address, telephone and/or fax number, electronic mail address, social security number or other patient identification number, date of birth, date of treatment, medical treatment records, medical enrollment records, or medical claims records.

**Provider**

A provider is a licensed plan-approved dentist or physician.

Disclaimer: This booklet summarizes your indemnity dental plan. It is not intended to cover all the details of the indemnity dental plan. This booklet is not a contract and the benefits that are described can be terminated or amended by the University System of Georgia in its sole discretion. Should any questions arise, the master contract and the contract of the administration are the final authorities in determining benefits.

# House Bill 721

## Legislation Passed by the 2003 Georgia General Assembly and Signed by the Governor

House Bill 721- Prohibits Insurers From Using an Individual's Social Security Number on his/her Health Insurance Identification Card Effective Date: On or after July 1, 2004

Summary Highlights

Health insurance identification cards issued by any insurer on or after July 1, 2004, shall not display the contract holder's social security number for any purpose or in any manner.

Disclaimer: This information is provided for informational purposes only and no warranty is provided for accuracy. Members should consult legal counsel regarding legal rights and responsibilities.
Revised July 2008