COMPREHENSIVE STANDARD

utilizing the

Delta Dental Premier Network

Dental Benefit Plan Summary

The benefits provided by this plan are insured by Delta Dental of Nebraska

DENTAL BENEFIT PLAN SUMMARY

This is a Summary of your Group Dental Program
(**PROGRAM**) prepared for Covered Persons with:

Comprehensive Standard

This Program has been established and is maintained and administered in accordance with the provisions of your Group Dental Plan Contract issued by Delta Dental of Nebraska (**PLAN**).

IMPORTANT

This booklet is subject to the provisions of the Group Dental Agreement and cannot modify this agreement in any way; nor shall you accrue any rights because of any statement in or omission from this booklet.

DELTA DENTAL OF NEBRASKA
Administrative Offices
Atrium Executive Square
11235 Davenport Street, Suite 105
Omaha, NE 68154
(402) 397-4878 or (800) 736-0710

DELTA DENTAL OF NEBRASKA
NOTICE OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Delta Dental of Nebraska understands that medical information about you and your health is personal, and we are committed to protecting your medical information. Individually identifiable information about your past, present or future health or condition, the provision of health care to you, or payment for such health care is considered "Protected Health Information" ("PHI").

Our Permitted Uses and Disclosures of Your Protected Health Information are:

We use and disclose PHI about you for treatment, payment, and health care operations.

Treatment: We may disclose PHI to your dentist(s) for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seek information as to whether the service has been previously provided.

Payment: We disclose your PHI in order to fulfill our duty to provide your coverage, determine your benefits, and make payment for services provided to you. For example, we use your PHI in order to process your claims.

Health Care Operations: We disclose your PHI as a part of certain operations, such as quality improvement. For example, we may use your PHI to evaluate the quality of dental services that were performed.

We may be asked by the sponsor of your health plan to provide your PHI to the sponsor. If we are asked to do so, we intend to honor such requests unless we are prohibited by law from doing so.

We may use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may give out PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We provide PHI when otherwise required by law, such as for law enforcement in specific circumstances, or for judicial or administrative proceedings. In any other situation, we will ask for your written authorization before using or disclosing your PHI. If you choose to sign an authorization to allow disclosure of your PHI, you can later revoke that authorization to stop any future uses and disclosures (other than for treatment, payment and health care operations).

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and send the new notice to you. You can also request a copy of our notice at any time.

Individual Rights: In most cases, you have the right to view or get a copy of your PHI. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your PHI for treatment, payment and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations, if you clearly state that disclosure of all or part of your PHI could endanger you.

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty: We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, or if you have any questions, complaints or concerns, please contact:

Customer Service
1-866-827-3319

Delta Dental of Nebraska
P.O. Box 245
Minneapolis, MN 55440-0245

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DESCRIPTION OF COVERED PROCEDURES

Pretreatment Estimate
(Estimate of Benefits)

IT IS RECOMMENDED THAT A PRETREATMENT ESTIMATE BE SUBMITTED TO THE PLAN PRIOR TO TREATMENT IF YOUR DENTAL TREATMENT INVOLVES MAJOR RESTORATIVE, PERIODONTIC OR PROSTHETIC CARE (SEE DESCRIPTION OF COVERAGES), TO ESTIMATE THE AMOUNT OF PAYMENT. THE PRETREATMENT ESTIMATE IS A VALUABLE TOOL FOR BOTH THE DENTIST AND THE PATIENT. SUBMISSION OF A PRETREATMENT ESTIMATE ALLOWS THE DENTIST AND THE PATIENT TO KNOW WHAT BENEFITS ARE AVAILABLE TO THE PATIENT BEFORE BEGINNING TREATMENT. THE PRETREATMENT ESTIMATE OUTLINES THE PATIENT'S RESPONSIBILITY TO THE DENTIST WITH REGARD TO CO-PAYMENTS, DEDUCTIBLES AND NON-COVERED SERVICES AND ALLOWS THE DENTIST AND THE PATIENT TO MAKE ANY NECESSARY FINANCIAL ARRANGEMENTS BEFORE TREATMENT BEGINS. THIS PROCESS DOES NOT PRIOR AUTHORIZE THE TREATMENT NOR DETERMINE ITS DENTAL OR MEDICAL NECESSITY. THE ESTIMATED DELTA DENTAL PAYMENT IS BASED ON THE PATIENT'S CURRENT ELIGIBILITY AND CURRENT AVAILABLE CONTRACT BENEFITS. THE SUBSEQUENT SUBMISSION OF OTHER CLAIMS, A CHANGE IN ELIGIBILITY, A CHANGE IN THE CONTRACT COVERAGE OR THE EXISTENCE OF OTHER COVERAGE MAY ALTER THE DELTA DENTAL FINAL PAYMENT AMOUNT AS SHOWN ON THE PRETREATMENT ESTIMATE FORM.

After the examination, your dentist will establish the dental treatment to be performed. If the dental treatment necessary involves major restorative, periodontic or prosthetic care, a participating dentist should submit a claim form to the Plan outlining the proposed treatment.

A Pretreatment Estimate of Benefits statement will be sent to you and your dentist. You will be responsible for payment of any deductibles and coinsurance amounts or any dental treatment that is not considered a covered service under the Plan.

Benefits

The Program covers the following dental procedures when they are performed by a licensed dentist and when necessary and customary as determined by the standards of generally accepted dental practice. The benefits under this Program shall be provided whether the dental procedures are performed by a duly licensed physician or a duly licensed dentist, if otherwise covered under this Program, provided that such dental procedures can be lawfully performed within the scope of a duly licensed dentist.

As a condition precedent to the approval of claim payments, the Plan shall be entitled to request and receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which a dentist's care is provided, such information and records relating to a Covered Person as may be required to pay claims. Also, the Plan may require that a Covered Person be examined by a dental consultant retained by the Plan in or near the Covered Person's place of residence. The Plan shall hold such information and records confidential.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN THE DELTA DENTAL PREMIER NETWORK PRIOR TO RECEIVING DENTAL CARE.

Delta Dental of Nebraska does not determine whether a service submitted for payment or benefit under this Plan is a dental procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. Delta Dental of Nebraska evaluates dental procedures submitted to determine if the procedure is a covered benefit under your dental plan. Your dental Plan includes a preset schedule of dental services that are eligible for benefit by the Plan. Other dental services may be recommended or prescribed by your dentist which are dentally necessary,

offer you an enhanced cosmetic appearance, or are more frequent than covered by the Plan. While these services may be prescribed by your dentist and are dentally necessary for you, they may not be a dental service that is benefited by this Plan or they may be a service where the Plan provides a payment allowance for a service that is considered to be optional treatment. If the Plan gives you a payment allowance for optional treatment that is covered by the plan, you may apply this Plan payment to the service prescribed by your dentist which you elected to receive. Services that are not covered by the Plan or exceed the frequency of Plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for dental services that are not covered or benefited by the Plan. Determination of services necessary to meet your individual dental needs is between you and your dentist.

ONLY those services listed are covered. Deductibles and maximums are listed under the Summary of Dental Benefits. Services covered are subject to the limitations within the Benefits, Exclusions and Limitations sections described below. For estimates of covered services, please see the "Pretreatment Estimate" section of this booklet.

PREVENTIVE CARE
(Diagnostic & Preventive Services)

Oral Evaluations

Any type of evaluation (checkup or exam) is covered 1 time per 6-month period.

> NOTE: Comprehensive oral evaluations will be benefited 1 time per dental office, subject to the 1 time per 6-month period limitation. Any additional comprehensive oral evaluations performed by the same dental office will be benefited as a periodic oral evaluation and will be subject to the 1 time per 6-month period limitation.

Radiographs (X-rays)

- **Bitewings**- Covered at 1 series of bitewings per 12-month period.
- **Full Mouth (Complete Series) or Panoramic –** Covered 1 time per 60-month period.
- **Periapical(s)** – 4 single x-rays are covered per 12-month period.
- **Occlusal** – Covered at 2 series per 24-month period.

Dental Cleaning

- **Prophylaxis or Periodontal Maintenance** – Any combination of these procedures is covered 1 time per 6-month period.

  Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

  > NOTE: A prophylaxis performed on a Covered Person under the age of 14 will be benefited as a child prophylaxis. A prophylaxis performed on a Covered Person age 14 or older will be benefited as an adult prophylaxis.

  Periodontal Maintenance is a procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Fluoride Treatment

- Topical application of fluoride. Covered 1 time per 12-month period for dependent children through the age of 18.

EXCLUSIONS – Coverage is NOT provided for:

1. Oral hygiene instructions.

BASIC SERVICES

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Amalgam (silver) Restorations – Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

- **Anterior (front) Teeth** - Treatment to restore decayed or fractured permanent or primary anterior (front) teeth.

- **Posterior (back) Teeth** - Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.

  Benefits shall be limited to the same surfaces and allowances for amalgam (silver filling). The patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

LIMITATION: Coverage for amalgam or composite restorations shall be limited to only 1 service per tooth surface per 24-month period.

Other Preventive and Basic Services

- **Pre-fabricated or Stainless Steel Crown -** Covered 1 time per 60-month period for eligible dependent children through the age of 18.

- **Sealants or Preventive Resin Restorations** - Any combination of these procedures is covered 1 time per lifetime for permanent first and second molars of eligible dependent children through the age of 15.

- **Space Maintainers -** Covered 1 time per lifetime on eligible dependent children through the age of 16 for extracted primary posterior (back) teeth.
  LIMITATION: Repair or replacement of lost/broken appliances are not a covered benefit.

Adjunctive General Services

- **Intravenous Conscious Sedation and IV Sedation –** Covered when performed in conjunction with complex surgical service.

  LIMITATION: Intravenous conscious sedation and IV sedation will not be covered when performed with non-surgical dental care.

EXCLUSIONS – Coverage is NOT provided for:

1. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care.

2. Case presentation and office visits.

3. Athletic mouthguard, enamel microabraision, and odontoplasty.

4. Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes but is not limited to whitening agents, tooth bonding and veneers.

5. Placement or removal of sedative filling, base or liner used under a restoration.

6. Restorative cast post and core build-up, including pins and posts.

7. Amalgam or composite restorations placed for preventive or cosmetic purposes.

Basic Endodontic Services (Nerve or Pulp Treatment)

Endodontic Therapy on Primary Teeth

- **Pulpal Therapy**
- **Therapeutic Pulpotomy**

Endodontic Therapy on Permanent Teeth

- **Root Canal Therapy**

LIMITATION: All of the above procedures are covered 1 time per tooth per lifetime.

EXCLUSIONS - Coverage is NOT provided for:

1. Retreatment of endodontic services that have been previously benefited under the Plan.
2. Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
3. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
4. Intentional reimplantation.
5. Apicoectomy.
6. Root Amputation.
7. Apexification.
8. Retrograde filling.
9. Hemisection.

Periodontics (Gum & Bone Treatment)

Basic Non Surgical Periodontal Care – Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- **Periodontal scaling & root planning –** Covered 1 time per 24 months
- **Full mouth debridement--** Covered 1 time per lifetime

Complex Surgical Periodontal Care – Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this plan.

- **Gingivectomy/gingivoplasty**
- **Gingival curettage**
- **Gingival flap**

- **Apically positioned flap**
- **Mucogingival surgery**
- **Osseous Surgery**
- **Bone replacement graft**
- **Pedicle soft tissue graft**
- **Free soft tissue graft**
- **Subepithelial connective tissue graft**
- **Soft tissue allograft**
- **Combined connective tissue and double pedicle graft**
- **Distal/proximal wedge**

LIMITATION: Only 1 complex surgical periodontal service is a benefit covered 1 time per 36-month period per single tooth or multiple teeth in the same quadrant.

EXCLUSIONS – Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as crown lengthening.
2. Bacteriologic tests for determination of periodontal disease or pathologic agents.
3. The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
4. Provisional splinting, temporary procedures or interim stabilization of teeth.
5. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis, inhalation of nitrous oxide or therapeutic drug injections, drugs, or medicaments for non-surgical and surgical periodontal care, regardless of the method of administration.

Oral Surgery (Tooth, Tissue, or Bone Removal)

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty

LIMITATION: The Other Complex Surgical Procedures are covered only when required to prepare for dentures.

LIMITATIONS

Reconstructive Surgery benefits shall be provided for reconstructive surgery when such dental procedures are incidental to or follows surgery resulting from injury, illness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, provided, however, that such procedures are dental reconstructive surgical procedures.

EXCLUSIONS - Coverage is NOT provided for:

1. Intravenous conscious sedation and IV sedation when performed with non-surgical dental care.
2. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration.
3. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
4. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
5. Implant maintenance or repair to an implant or implant abutment.
6. Surgical exposure of impacted or unerupted tooth for orthodontic reasons.
7. Any oral surgery except for simple and surgical extractions.
8. Surgical repositioning of teeth.
9. Inpatient or outpatient hospital expenses.
10. Cytology sample collection – Collection of oral cytology sample via scraping of the oral mucosa.

COMPLEX OR MAJOR RESTORATIVE SERVICES

Services performed to restore lost tooth structure as a result of decay or fracture

Gold foil restorations – Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances**.** The patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit. Covered 1 time per 24-month period.

Inlays – Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION: If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

Onlays and/or Permanent Crowns - Covered 1 time per 5 year period per tooth.

Implant Crowns – See Prosthetic Services.

Crown Repair – Covered 1 time per 12-month period per tooth.

EXCLUSIONS – Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.

2. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

3. Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.

4. Placement or removal of sedative filling, base or liner used under a restoration.

5. Restorative cast post/core or core build-up

6. Canal prep & fitting of preformed dowel & post.

7. Temporary, provisional or interim crown.

8. Occlusal procedures, including occlusal guard and adjustments.

Prosthetic Services (Dentures, Partials, and Bridges)

Reline and Rebase – Covered 1 per 24-month period;

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) – Covered 1 per 6-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Denture Adjustments – Covered 2 times per 12-month period:

- when the denture is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the denture.

Partial and Bridge Adjustments – Covered 2 times per 24-month period:

- when the partial or bridge is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) – Covered 1 time per 5 year period;

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;

- if 5 years have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) – Covered 1 time per 5 year period;

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last 5 years;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Single Tooth Implant Body, Abutment and Crown – Covered 1 time per 5-year period for covered persons age 16 and over. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a Pretreatment Estimate be requested to estimate the amount of payment prior to beginning treatment.

EXCLUSIONS – Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Initial installation of full or partial dentures, implants or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a Covered Person under this Plan. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this Plan for more than 24 months.
3. Coverage for congenitally missing teeth. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this dental benefit plan for more than 24 months.
4. Interim removable or fixed prosthetic appliances (dentures, partials or bridges)
5. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges)
6. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
7. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
8. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
9. Services or supplies that have the primary purpose of improving the appearance of your teeth.
10. Placement or removal of sedative filling, base or liner used under a restoration.
11. Restorative cast post and core build-up, including pins and posts.

12. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.

13. Implant maintenance or repair to an implant or implant abutment.

14. Coverage shall be limited to the least expensive professionally acceptable treatment.

Exclusions
Coverage is NOT provided for:

a) Dental services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving Medical Assistance.

b) Dental services or health care services not specifically covered under the Group Dental Plan Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).

c) New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.

d) Dental services performed for cosmetic purposes. NOTE: Dental services are subject to post-payment review of dental records. If services are found to be cosmetic, we reserve the right to collect any payment and the member is responsible for the full charge.

e) Dental services completed prior to the date the Covered Person became eligible for coverage.

f) Services of anesthesiologists.

g) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.

h) Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

i) Dental services performed other than by a licensed dentist, licensed physician, his or her employees.

j) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

k) Material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.

l) Implant maintenance or repair to an implant or implant abutment.

m) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.

n) Orthodontic treatment services, unless specified in this Dental Benefit Plan Summary as a covered dental service benefit.

o) Case presentations, office visits and consultations.

p) Incomplete, interim or temporary services.

q) Initial installation of full or partial dentures, implants or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a Covered Person under this Plan. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this Plan for more than 24 months.

r) Corrections of congenital conditions during the first 24 months of continuous coverage under this Plan.

s) Athletic mouth guards, enamel microabraision and odontoplasty.

t) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.

u) Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.

v) Bacteriologic tests.

w) Cytology sample collection.

x) Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.

y) Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).

z) Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).

aa) Services for the replacement of an existing partial denture with a bridge.

bb) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.

cc) Provisional splinting, temporary procedures or interim stabilization.

dd) Placement or removal of sedative filling, base or liner used under a restoration.

ee) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.

ff) Oral hygiene instruction.

gg) Restorative cast post/core or core build-up, including pins and posts.

hh) Occlusal procedures, including occlusal guard and adjustments.

ii) Amalgam or composite restorations placed for preventive or cosmetic purposes.

Limitations

a) Optional Treatment Plans: in all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Person and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.

b) Reconstructive Surgery: benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, provided, however, that such services are dental reconstructive surgical services.

For other dental procedure exclusions and limitations, refer to the Description of Coverages in this Dental Benefit Plan Summary.

Post Payment Review

Dental services are evaluated after treatment is rendered for accuracy of payment, benefit coverage and potential fraud or abuse as defined in the Health Insurance Portability and Accountability Act of 1996 – Public Law 102-191. Any payments for dental services completed solely for cosmetic purposes or payments for services not performed as billed, are subject to recovery. Delta Dental's right to conduct post payment review and its right of recovery exists even if a Pretreatment Estimate was submitted for the service.

Optional Treatment Plans

In all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Person and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.

ELIGIBILITY

Covered Persons under this Program are:

Employees

a) All eligible employees who have met the eligibility requirements as established by the Group and stated within this Dental Benefit Plan Summary under Effective Date of Coverage.

b) Employees on Family and Medical Leave as mandated by the Federal FMLA.

Dependents

A) Spouse, meaning:

1. Married;
2. Legally separated;

B) Dependent children to the age of 26, including:

1. Natural-born and legally adopted children (including children placed with you for legal adoption). NOTE: A child's placement for adoption terminates upon the termination of the legal obligation of total or partial support.
2. Stepchildren who reside with you.
3. Grandchildren who are financially dependent on you and reside with you.
4. Children who are required to be covered by reason of a Qualified Medical Child Support Order. You can obtain, without charge, a copy of procedures governing Qualified Medical Child Support Orders ("QMCSOs") from the Plan Administrator.
5. Children who become handicapped prior to reaching the Plan's limiting age if:
    - they are primarily dependent upon you; and
    - are incapable of self-sustaining employment because of physical handicap, mental retardation, mental illness or mental disorders;

NOTE: If both you and your spouse are employees of the employer, you may be covered as either an employee or as a dependent, but not both. Your eligible dependent children may be covered under either parent's coverage, but not both.

Effective Dates of Coverage

Eligible Employee:

You are eligible to be covered under this Program when the Program first became effective, or if you are a new employee of the Group, on the date following your company's probationary period.

Eligible Dependents:

Your eligible dependents, as defined, are covered under this Program:

a) On the date you first become eligible for coverage, if dependent coverage is provided or elected.
b) On the date you first acquire eligible dependents, or add dependent coverage subject to the open enrollment requirements of the Group, if any.
c) On the date a new dependent is acquired if you are already carrying dependent coverage.
   LIMITATION: Dependents of an eligible employee who are in active military service are not eligible for coverage under the Program.

Children may be added to the Program at the time the eligible employee originally becomes effective or may be added anytime up to 30 days following the child's 3rd birthday. If a child is born or adopted after the employee's original effective date, such child may be added anytime between birth (or date of adoption) and 30 days following the child's 3rd birthday. In the event that the child is not added by 30 days following their 3rd birthday, that child may be added only if there is a Family Status Change or at the next Open Enrollment period, if any.

The eligibility of all Covered Persons, for the purposes of receiving benefits under the Program, shall, at all times, be contingent upon the applicable monthly payment having been made for such Covered Person by the Group on a current basis.

Open Enrollment

Contact your employer for your designated Open Enrollment period, if any.

Family Status Change

Your benefit elections are intended to remain the same for the entire Coverage Year. During the Coverage Year, you will be allowed to change your benefits only if you experience an eligible Family Status Change which includes:

- Change in legal marital status such as marriage or divorce.
- Change in number of dependents in the event of birth, adoption, or death.
- Change in your or your spouse's employment - either starting or losing a job.
- Change in your or your spouse's work schedule, such as going from full-time to part-time or part-time to full-time, or beginning or ending an unpaid leave of absence.
- Change in dependent status, such as if a child reaches maximum age under the Plan.
- Change in residence or work location so you are no longer eligible for your current health plan.
- Become eligible for Medicare, Medicaid or Children's Health Insurance Program (CHIP) coverage.
- Termination of Medicare, Medicaid or Children's Health Insurance Program (CHIP) coverage because you or your dependents are no longer eligible.

- Loss of other coverage.

Due to federal regulations, the changes you make to your benefits must be consistent with the Family Status Change event that you experience. For example, if you have a baby, it is consistent to add your newborn to your current dental coverage but it is not consistent to drop your dental coverage altogether.

If you experience one of the above eligible Family Status Changes during the year, you have 31 days (except in the case of qualification for or termination of employment assistance under Medicaid/CHIP, in which case the employee has 60 days after the date of eligibility) from the event to change your elections. If you do not change your benefits within 31 days of the event, you will not be allowed to make changes until the next Open Enrollment period. You may obtain a Family Status Change Form by contacting your Employer. All changes are effective the date of the change.

Termination of Coverage

Your coverage and that of your eligible dependents ceases on the earliest of the following dates:

a) The end of the month in which (1) you cease to be eligible; (2) your dependent is no longer eligible as a dependent under the Program.
b) On the date the Program is terminated.
c) On the date the Group terminates the Program by failure to pay the required Group Subscriber payments, except as a result of inadvertent error.

For extended eligibility, see Continuation of Coverage.

The Group or Plan Sponsor reserves the right to terminate the Plan, in whole or in part, at any time (subject to applicable collective bargaining agreements). Termination of the Plan will result in loss of benefits for all covered persons. If the Plan is terminated, the rights of the Plan Participants are limited to covered expenses incurred before termination.

Continuation of Coverage (COBRA)

Dental benefits may be continued should any of the following events occur, provided that at the time of occurrence this Program remains in effect and you or your spouse or your dependent child is a Covered Person under this Program:

QUALIFYING EVENT	WHO MAY CONTINUE	MAXIMUM CONTINUATION PERIOD
Employment ends, retirement, leave of absence, lay-off, or employee becomes ineligible (except gross misconduct dismissal)	Employee and dependents	Earliest of: 1. 18 months, or 2. Enrollment in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Divorce, marriage dissolution, or legal separation	Former Spouse and any dependent children who lose coverage	Earliest of: 1. 36 months or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Death of Employee	Surviving spouse and dependent children	Earliest of: 1. 36 months or 2. Enrollment date in other group coverage or Medicare, or

		3. Date coverage would otherwise end.

Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Dependents lose eligibility due to Employee's entitlement to Medicare	Spouse and dependents	Earliest of: 1. 36 months, 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Employee's total disability	Employee and dependents	Earliest of: 1. 29 months or 2. Date total disability ends or 3. Enrollment date in other group coverage or Medicare.
Retirees of employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within 1 year of filing)	Retiree and dependents	Earliest of: 1. Enrollment date in other group coverage, or 2. Death of retiree or dependent electing COBRA.
Surviving Dependents of retiree on lifetime continuation due to the bankruptcy of the employer	Surviving Spouse and dependents	Earliest of: 1. 36 months following retiree's death, or 2. Enrollment date in other group coverage.

You or your eligible dependents have 60 days from the date you lose coverage, due to one of the events described above, to inform the Group that you wish to continue coverage.

1. Choosing Continuation

   If you lose coverage, your employer must notify you of the option to continue coverage within 10 days after employment ends. If coverage for your dependent ends because of divorce, legal separation, or any other change in dependent status, you or your covered dependents must notify your employer within 60 days.

   You or your covered dependents must choose to continue coverage by notifying the employer in writing. You or your covered dependents have 60 days to choose to continue, starting with the date of the notice of continuation or the date coverage ended, whichever is later. Failure to choose continuation within the required time period will make you or your covered dependents ineligible to choose continuation at a later date. You or your covered dependents have 45 days from the date of choosing continuation to pay the first continuation charges. After this initial grace period, you or your covered dependents must pay charges monthly in advance to the employer to maintain coverage in force.

   Charges for continuation are the group rate plus a two percent administration fee. All charges are paid directly to your employer. If you or your covered dependents are totally disabled, charges for continuation are the group rate plus a two percent administration fee for the first 18 months. For months 19 through 29, the employer may charge the group rate plus a 50 percent administration fee.

2. Second qualifying event

   If a second qualifying event occurs during continuation, a dependent qualified beneficiary may be entitled to election rights of their own and an extended continuation period. This rule only applies when the initial qualifying event for continuation is the employee's termination of employment, retirement, leave of absence, layoff, or reduction of hours.

   When a second qualifying event occurs such as the death of the former covered employee, the dependent must notify the employer of the second event within 30 days after it occurs in order to continue coverage. In no event will the first and second period of continuation extend beyond the earlier of the date coverage would otherwise terminate or 36 months.

   A qualified beneficiary is any individual covered under the dental plan the day before the qualified event as well as a child who is born or placed for adoption with the covered employee during the period of continuation coverage.

3. Terminating Continuation of Coverage – COBRA

   Continuation of Coverage – COBRA for you and your eligible dependents, if selected, shall terminate on the last day of the month in which any of the following events first occur:

   a) The expiration of the specified period of time for which Continuation of Coverage – COBRA can be maintained; as mandated by applicable State or Federal law;

   b) This Program is terminated by the Group Subscriber;

   c) The Group Subscriber's or Covered Person's failure to make the payment for the Covered Person's Continuation of Coverage;

Questions regarding Continuation of Coverage – COBRA should be directed to your employer. Your employer will explain the regulations, qualifications and procedures required when you continue coverage.

PLAN PAYMENTS

Participating Dentist Network

A Delta Dental Premier dentist is a dentist who has signed a participating and membership agreement with his/her local Delta Dental Plan. The dentist has agreed to accept Delta Dental's Maximum Amount Payable as payment in full for covered dental care. Delta Dental's Maximum Amount Payable is a schedule of fixed dollar maximums established solely by Delta Dental for dental services provided by a licensed dentist who is a participating dentist. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental Premier dentist has agreed not to bill more than Delta Dental's Maximum Amount Payable. A Delta Dental Premier dentist has also agreed to file the claim directly with Delta Dental.

Listings of participating providers are available to Subscribers as a separate document and are furnished by the Group without charge. Names of Participating Dentists can be obtained, upon request, by calling Delta, from directory listings furnished to the Group or from the Plan's internet web site at www.deltadentalne.org. Refer to the General Information section of this booklet for detailed information on how to locate a participating provider using the Plan's internet web site.

Covered Fees

Under this Program, YOU ARE FREE TO GO TO THE DENTIST OF YOUR CHOICE. You may have additional out-of-pocket costs if your dentist is not a Delta Dental Premier dentist with the plan. This payment difference could result in some financial liability to you. The amount is dependent on the nonparticipating dentist's charges in relation to the Table of Allowances determined by Delta.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN THE DELTA DENTAL PREMIER NETWORK PRIOR TO RECEIVING DENTAL CARE.

Claim Payments

PAYMENTS ARE MADE BY THE PLAN ONLY WHEN THE COVERED DENTAL PROCEDURES HAVE BEEN COMPLETED. THE PLAN MAY REQUIRE ADDITIONAL INFORMATION FROM YOU OR YOUR PROVIDER BEFORE A CLAIM CAN BE CONSIDERED COMPLETE AND READY FOR PROCESSING. IN ORDER TO PROPERLY PROCESS A CLAIM, THE PLAN MAY BE REQUIRED TO ADD AN ADMINISTRATIVE POLICY LINE TO THE CLAIM. DUPLICATE CLAIMS PREVIOUSLY PROCESSED WILL BE DENIED.

ANY BENEFITS PAYABLE UNDER THIS PLAN ARE NOT ASSIGNABLE BY ANY COVERED PERSON OR ANY ELIGIBLE DEPENDENT OF ANY COVERED PERSON.

Delta Dental Premier Dentists:

Claim payments are based on the Plan's Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental Premier dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental Premier dentists is the lesser of: (1) The fee pre-filed by the dentist with their Delta Dental organization; (2) The Maximum Amount Payable as determined by Delta Dental; (3) The fee charged or accepted as payment in full by the Delta Dental Premier dentist regardless of the amount charged. All Plan Payment Obligations are determined prior to the calculation of any patient co-payments and deductibles as provided under the patient's Delta Dental program.

Nonparticipating Dentists:

Claim payments are based on the Plan's Payment Obligation, which for nonparticipating dentists is the treating dentist's submitted charge or the Table of Allowances established solely by Delta Dental, whichever is less. The Table of Allowances is a schedule of fixed dollar maximums established by Delta Dental for services rendered by a licensed dentist who is a nonparticipating dentist. Claim payments are sent directly to the Covered Person.

THE COVERED PERSON IS RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY THE NONPARTICIPATING DENTIST. WHEN SERVICES ARE OBTAINED FROM A NON-PARTICIPATING PROVIDER, ANY BENEFITS PAYABLE UNDER THE GROUP CONTRACT ARE PAID DIRECTLY TO THE COVERED PERSON.

Coordination of Benefits (COB)

The **Coordination** of **Benefits** (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The

Plan that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** does not exceed 100% of the total **Allowable expense**.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile "no fault" and traditional "fault" type contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses.

(2) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar

reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

(3) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

(4) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract 18 permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

(5) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.

B. (1) Except as provided in Paragraph (2), a **Plan** that does not contain a **coordination** of **benefits** provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.

D. Each **Plan** determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or 19 retiree is the **Primary plan** and the

Plan that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

•The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or

•If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

•The **Plan** covering the **Custodial parent**;

•The **Plan** covering the spouse of the **Custodial parent**;

•The **Plan** covering the **non-custodial parent**; and then

•The **Plan** covering the spouse of the **non-custodial parent**.

(c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order

of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more **Closed panel** plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. [Organization responsibility for **COB** administration] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. [Organization responsibility for **COB** administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This** plan must give [Organization responsibility for **COB** administration] any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, [Organization responsibility for **COB** administration] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. [Organization responsibility for **COB** administration] will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by [Organization responsibility for **COB** administration] is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Claim and Appeal Procedures

Initial Claim Determinations

All claims should be submitted within 12 months of the date of service. Upon receipt of a claim, we will respond and provide you, within 15 business days, any necessary forms, instructions and reasonable assistance to enable you to comply with reasonable requirements and any other policy conditions.

Within 15 business days of receipt of proof of loss from the claimant, we will initiate an investigation of the claim. We will affirm or deny liability within a reasonable time and pay the claim, or any undisputed portion thereof, within 15 business days of a determination of liability.

Each claim denial or claim payment shall be made in writing and provided to you with an Explanation of Benefits that includes, if applicable, the name of the provider, the services covered, the amount charged, dates of service and a reasonable explanation of the decision. There will be no penalty for noncompliance with our precertification and/or concurrent review unless the penalty for the same is specifically and clearly set forth in this plan booklet.

We will not withhold any portion of any benefit payable on the basis that the sum withheld is an adjustment or correction of an overpayment made on a prior claim unless documented evidence of such overpayment made on a prior claim unless documented evidence of such overpayment and written authorization from the claimant permitting such withholding

First Level Grievance Appeal

If you are not satisfied with the initial determination made by Delta Dental, you may file a written grievance within 45 days. Any such correspondence should be sent the following address:

Delta Dental of Nebraska
Attention: Appeals Unit
PO Box 551
Minneapolis, MN 55440-0551

Delta Dental will respond to your notice of grievance within 15 business days. If, however, Delta Dental cannot make a determination within 15 business days due to circumstances beyond our control we will take an additional 15 business days to make the determination. If this is necessary Delta Dental will provide you with written notice of the need for this additional time to render a decision. You may submit written comments, documents, or other information in support of your appeal. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim (whether or not presented or available at the initial determination) and the initial determination will not be given any weight. In addition, Delta Dental will also provide you with the name, phone number and address of the person who will be coordinating your appeal.

Second Level Grievance Appeal

If you still are not satisfied with the determination following your first appeal you have the right to request a second level grievance. If you request a second level grievance appeal Delta Dental will appoint a grievance panel to consider your case. This panel will meet within 45 business days of the date that you

request a second level grievance appeal. In addition, you have the right to attend the panel if you so desire. If you cannot make the panel Delta Dental, at your request, will offer you the opportunity to communicate with the grievance panel by conference call. The panel will issue a decision to you within five business days of the grievance panel.

You may submit written comments, documents, or other information in support of your appeal. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim (whether or not presented or available at the initial determination) and the initial determination will not be given any weight.

The review will be conducted by someone different from the original decision-makers and without deference to any prior decision. Because all benefit determinations are based on a preset schedule of dental services eligible under your plan, claims are not reviewed to determine dental necessity or appropriateness. In all cases where professional judgment is required to determine if a procedure is covered under your plan's schedule of benefits, we will consult with a dental professional who has appropriate training and experience. In such a case, this professional will not be the same individual whose advice was obtained in connection with the initial adverse benefit determination (nor a subordinate of any such individual). In addition, we will identify any dental professional whose advice was obtained on our behalf, without regard to whether the advice was relied upon in making the benefit determination. If, after review, we continue to deny the claim, you will be notified in writing.

If you are still not satisfied after the resolution of your claim following your appeals, you have the right to contact the Nebraska Department of Insurance at the following address:

Nebraska Department of Insurance
Terminal Building
941 "O" Street, Suite 400
Lincoln, NE 68508-3639
Phone: (877) 564-7323
TDD: (800) 833-7352

Authorized Representative
You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. However, no authorization is required for your treating dentist to make a claim or appeal on your behalf. The authorization form must be in writing, signed by you, and include all the information required in our Authorized Representative form. This form is available at our web site or by calling Customer Service. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

GENERAL INFORMATION

Health Plan Issuer Involvement

Delta Dental is the health plan issuer involved with the Plan. It's address is stated on the back cover of this booklet. The benefits under the Plan are guaranteed by Delta Dental under the Contract (for insured plans).

Privacy Notice

Delta Dental of Nebraska will not disclose non-public personal financial or health information concerning persons covered under out dental benefit plans to non-affiliated third parties except as permitted by law or required to adjudicate claims submitted for dental services provided to persons covered under our dental benefit plans.

How to Find a Participating Dentist

You have several options that are available to help you find a network dentist or verify that your current dentist is in the network.

- When you call to make a dental appointment, always verify the dentist is a participating dentist. **Be sure to specifically state that your employer is providing the Dental program.**
- Contact our Customer Service Center at: (800) 553-9536

Using Your Dental Program

Dentists who participate with Delta under this Program are independent contractors. The relationship between you and the participating dentist you select to provide your dental services is strictly that of provider and patient. Delta cannot and does not make any representations as to the quality of treatment outcomes of individual dentists, nor recommends that a particular dentist be consulted for professional care.

All claims should be submitted within 12 months of the date of service.

If your dentist is a participating dentist, the claim form will be available at the dentist's office.

If your dentist is nonparticipating, claim forms are available by calling:

Delta Dental of Nebraska - 1-866-827-3319

The Plan also accepts the standard American Dental Association (ADA) claim form used by most dentists.

The dental office will file the claim form with the Plan; however, you may be required to assist in completing the patient information portion on the form (Items 1 through 14).

During your first dental appointment, it is very important to advise your dentist of the following information:

∗ YOUR DELTA GROUP NUMBER

∗ YOUR EMPLOYER (GROUP NAME)

∗ YOUR IDENTIFICATION NUMBER (your dependents must use **YOUR** Identification number)

∗ YOUR BIRTHDAY AND THE BIRTH DATES OF YOUR SPOUSE AND DEPENDENT CHILDREN

Cancellation and Renewal

The Program may be canceled by the Plan only on an anniversary date of the Group Dental Plan Contract, or at any time the Group fails to make the required payments or meet the terms of the Contract.

Upon cancellation of the Program, Covered Persons of the Group have no right to continue coverage under the Program or convert to an individual dental coverage contract.

DELTA DENTAL OF NEBRASKA

FOR CLAIMS AND ELIGIBILITY
P.O. Box 245
Minneapolis, Minnesota 55440-0245
1-866-827-3319

FOR APPEALS
P.O. Box 551
Minneapolis, Minnesota 55440-0551

CORPORATE LOCATION
Atrium Executive Square
11235 Davenport Street, Suite 105
Omaha, Nebraska 68154
(402) 397-4878 or (800) 736-0710