Delta Dental PPO℠ Plus Premier®

Our national PPO program

Welcome!

Your dental program is administered by Delta Dental of Nebraska, a nonprofit dental care corporation. Delta Dental of Nebraska is the state's dental benefits specialist. Good oral health is a vital part of good general health, and your Delta Dental program is designed to promote regular dental visits. We encourage you to take advantage of this program by calling your Dentist today for an appointment.

This Certificate, along with your Summary of Dental Plan Benefits, describes the specific benefits of your Delta Dental program and how to use them. If you have any questions about this program, please call our Customer Service department at 1-866-827-3319 or access our website at www.DeltaDentalNE.org. You can easily verify your own Benefit, Claims and eligibility information online 24 hours a day, seven days a week by visiting www.DeltaDentalNE.org and navigating to the Member Portal. The Member Portal will also allow you to print claim forms and ID cards, select paperless Explanation of Benefits statements (EOBs), search our Dentist directories, and read oral health tips.

We look forward to serving you!

TABLE OF CONTENTS

I. Delta Dental PPO℠ Plus Premier® Certificate 1
II. Definitions 1
III. Enrolling in This Plan 4
IV. Selecting a Dentist 4
V. Accessing Your Benefits 4
VI. How Payment is Made 5
VII. Benefit Categories 6
VIII. Exclusions and Limitations 6
IX. Coordination of Benefits 10
X. Reconsideration and Claims Appeal Procedure 13
XI. Termination of Coverage 14
XII. Continuation of Coverage 14
XIII. General Conditions 14

Please read this Certificate together with the Summary of Dental Plan Benefits. The Summary of Dental Plan Benefits lists the specific provisions of your group dental plan. If a statement in the Summary conflicts with a statement in this Certificate, the statement in the Summary applies to This Plan and you should ignore the conflicting statement in this Certificate.

I. Delta Dental PPO ℠ Plus Premier ® Certificate

Delta Dental of Nebraska, referred to herein as Delta Dental, issues this Certificate to you, the Subscriber. The Certificate is a summary of your dental benefits coverage. It reflects and is subject to a contract between Delta Dental and the Plan Sponsor/Contractor.

The Benefits provided under This Plan may change if any state or federal laws change.

Delta Dental agrees to provide Benefits as described in this Certificate and the Summary of Dental Plan Benefits.

All the provisions in the following pages form a part of this document as fully as if they were stated over the signature below.

IN WITNESS WHEREOF, this Certificate is executed at Delta Dental's home office by an authorized officer.



Tamera Robinson President
Delta Dental of Nebraska

II. Definitions

Adverse Benefit Determination

A determination by Delta Dental or its designee utilization review agent to deny, reduce or terminate a dental benefit, or a failure to provide or make payment (in whole or in part) of a dental benefit.

Allowed Amount

The amount permitted under the applicable fee schedule for this Plan, which was selected by your Plan Sponsor/Contractor, and upon which Delta Dental will base its payment for a Covered Service.

Benefit Year

The period during which any benefit frequency limitation and/or deductible and/or annual maximum payment will apply. This will be the calendar year, unless your Plan Sponsor/Contractor elects a different period to serve as the Benefit Year. (See the Summary of Dental Plan Benefits for your Benefit Year.) If the Benefit Year is based upon a calendar year, the terms Benefit Year and Calendar Year may be used interchangeably.

Benefits

Payment for the Covered Services that have been selected under This Plan.

Certificate

This document. Delta Dental will provide Benefits as described in this Certificate. Any changes in this Certificate will be based on changes to the contract between Delta Dental and the Plan Sponsor/Contractor.

Child(ren)

Your natural child(ren), stepchild(ren), adopted child(ren), child(ren) by virtue of legal guardianship, child(ren) who is/are residing with you during the waiting period for adoption or legal guardianship, or grandchildren who are financially dependent on you and reside with you.

Claim

A request for payment for a Covered Service. Claims are not conditioned upon your seeking advance approval, certification, or authorization to receive payment for any Covered Service.

Completion Date

The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- For dentures and partial dentures, on the delivery dates;
- For crowns and bridgework, on the permanent cementation date;
- For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Coinsurance

The percentage of the charge, if any, that you must pay for Covered Services.

Covered Services

The unique dental services selected for coverage as described in the Summary of Dental Plan Benefits and subject to the terms of this Certificate.

Deductible

The amount a person and/or a family must pay toward Covered Services before Delta Dental begins paying for those services under this Certificate. The Summary of Dental Plan Benefits lists the Deductible that applies to you, if any.

Delta Dental

Delta Dental of Nebraska, a nonprofit dental care corporation providing dental benefits.

Delta Dental Member Plan

An individual dental benefit plan that is a member of the Delta Dental Plans Association, the nation's largest, most experienced system of dental health plans.

Deny/Denied/Denial

When a Claim for a particular service is denied for payment due to certain contractual limitations/exclusions. You will be responsible for paying your Dentist the applicable amount for such service regardless of the Dentist's participating status.

Dentist

A person licensed to practice dentistry in the state or jurisdiction in which dental services are performed.

- **Delta Dental PPO℠ Dentist ("PPO Dentist")** – a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental PPO℠.
- **Delta Dental Premier® Dentist ("Premier® Dentist")** – a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental Premier®.

- **Nonparticipating Dentist** – a Dentist who has not signed an agreement with any Delta Dental Member Plan to participate in Delta Dental PPO℠ or Delta Dental Premier®.
- **Out-of-Country Dentist** – A Dentist whose office is located outside the United States and its territories. Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.

PPO℠ Dentists and Premier® Dentists are sometimes collectively referred to herein as **"Participating Dentists."** Wherever a definition or provision of this Certificate differs from another state's Delta Dental Member Plan and its agreement with Participating Dentists, the agreement in that state with that Dentist will be controlling.

Premier® Dentists, Nonparticipating Dentists, and Out-of-Country Dentists are sometimes collectively referred to herein as **"NonPPO℠ Dentists."**

Not billable to the Patient

When a Claim for a particular service is denied for payment due to certain contractual limitations/exclusions. You will not be responsible for payment for such service if you received the service from a Participating Dentist. However, you will be responsible for paying a Nonparticipating Dentist the applicable amount for such service.

Dependent(s)

Your dependents are as defined by the rules of eligibility as stated in your Summary of Dental Plan Benefits

Expedited Review

A review of a Grievance in which the time requirements are accelerated because standard time requirements could seriously jeopardize the life or health of the Covered Person, or the ability of the Covered Person to regain maximum function.

Grievance

A written complaint submitted by a Covered Person, a Covered Person's authorized representative, or a Covered Person's dental provider if allowed under applicable law, regarding; (a) the availability, delivery, or quality of dental care services, including a complaint regarding an Adverse Benefit Determination; (b) claims payment, handling, or reimbursement for dental care services; or

(c) matters pertaining to the contractual relationship between a Covered Person and Delta Dental.

Maximum Approved Fee

The Maximum Approved Fee is the lowest of:

- The Submitted Amount
- The lowest fee regularly charged, offered, or received by an individual Dentist for a dental service or supply, irrespective of the Dentist's contractual agreement with another dental benefits organization.
- The maximum fee that the local Delta Dental Member Plan approves for a given procedure in a given region and/or specialty based upon applicable Participating Dentist schedules and internal procedures.

Participating Dentists agree not to charge Delta Dental patients more than the Maximum Approved Fee for a Covered Service. In all cases, Delta Dental will make the final determination regarding the Maximum Approved Fee for a Covered Service.

Maximum Payment

The maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services. See the Summary of Dental Plan Benefits for the maximum payments applicable to This Plan.

Nonparticipating Dentist Fee

The maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist as determined by Delta Dental.

Open Enrollment Period

The period of time, as determined by the Plan Sponsor/Contractor, during which a Member may enroll or be enrolled for Benefits.

Out-of-Country Dentist Fee

The maximum fee allowed per procedure for services rendered by an Out-of-Country Dentist as determined by Delta Dental.

Plan Sponsor/Contractor

The employer, organization, group, or association sponsoring This Plan.

PPO℠ Dentist Schedule

The maximum fee allowed per procedure for services rendered by a PPO℠ Dentist as determined by that Dentist's local Delta Dental Member Plan.

Premier® Dentist Schedule

The maximum fee allowed per procedure for services rendered by a Premier® Dentist as determined by that Dentist's local Delta Dental Member Plan.

Pre-Treatment Estimate

A voluntary and optional process where Delta Dental issues a written estimate of dental benefits that may be available under your coverage for your proposed dental treatment.

Your Dentist submits the proposed dental treatment to Delta Dental in advance of providing the treatment.

A Pre-Treatment Estimate is for informational purposes only and is not required before you receive any dental care. It is not a prerequisite or condition for approval of future dental benefits payment. You will receive the same Benefits under This Plan whether or not a Pre-Treatment Estimate is requested. The benefits estimate provided on a Pre-Treatment Estimate notice is based on benefits available on the date the notice is issued. It is not a guarantee of future dental benefits or payment.

Availability of dental benefits at the time your treatment is completed depends on several factors. These factors include, but are not limited to, your continued eligibility for benefits, your available annual or lifetime Maximum Payments, any coordination of benefits, the status of your Dentist, This Plan's limitations and any other provisions, together with any additional information or changes to your dental treatment. A request for a Pre-Treatment Estimate is not a Claim or a preauthorization, precertification, determination of dental or medical necessity, or other reservation of future Benefits.

Processing Policies

Delta Dental's policies and guidelines used for Pre-Treatment Estimate and payment of Claims. The Processing Policies may be amended from time to time.

Special Enrollment Period

A period outside of the Open Enrollment Period in which you or your Dependent can change coverage under This Plan due to a qualifying life event.

Spouse, meaning

1. Married or; 2. Legally separated Standard Review

The requirement that Delta Dental conducts a review and responds to a non-urgent Grievance of a Covered Person within 15 business days from receipt of the Grievance.

Submitted Amount

The amount a Dentist bills to Delta Dental for a specific treatment or service. A Participating Dentist cannot charge you or your Dependents for the difference between this amount and the Maximum Approved Fee.

Subscriber

You, when the Plan Sponsor/Contractor notifies Delta Dental that you are eligible to receive Benefits under This Plan.

Summary of Dental Plan Benefits

A description of the specific provisions of your group dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Certificate, and supersedes any contrary provision of this Certificate.

This Plan

The dental coverage established for Members pursuant to this Certificate and your Summary of Dental Plan Benefits.

III. Enrolling in This Plan

The Open Enrollment Period, if applicable, will be established by the Plan Sponsor/Contractor and will occur on an annual basis. During the Open Enrollment Period, all eligible persons as defined in your Summary of Dental Plan Benefits may enroll in This Plan. You and/or your Dependents may not enroll in This Plan at any other time during the applicable Benefit Year except in the following instances:

a. Newly hired or rehired employees (if applicable): You will be eligible to enroll on the date for which employment compensation begins or, if applicable, that date plus the waiting period specified in the Summary of Dental Plan Benefits.

b. New Spouse: Your new Spouse will be eligible to enroll on the date of marriage.

c. Newborn: Your newborn will be eligible to enroll on the date of birth. or anytime up to 30 days following the child's 3rd birthday.

d. Legal adoptions or guardianships: Your newly adopted Child(ren) and/or the minor Child(ren) that you and/or your Spouse have guardianship over will be eligible to enroll anytime up to 30 days following the child's 3rd birthday. In the event the child is not added by 30 days following their 3rd birthday, the child maybe added only if there is a family status change or the next open enrollment period, if any.

e. New Stepchild: Your new stepchild will be eligible to enroll on the date that the Child's natural parent becomes a Dependent.

f. To the extent Plan Sponsor/Contractor permits Dependents other than those defined in this Certificate to enroll in This Plan, such Dependents will be eligible to enroll on the date that they become an eligible Dependent. Any such additional Dependents permitted by Plan Sponsor/Contractor shall be set forth in your Summary of Dental Plan Benefits.

g. All others will be permitted on the date that Delta Dental approves in writing the enrollment or listing of those people, unless compelled by a court or administrative order to otherwise provide Benefits for a Dependent.

IV. Selecting a Dentist

You may choose any Dentist. Your out-of-pocket costs are likely to be less if you go to a Delta Dental Participating Dentist.

To verify that a Dentist is a Participating Dentist, you can use Delta Dental's online Dentist Directory at www.deltadentalne.org/find- a-dentist or call 1-866-827-3319.

V. Accessing Your Benefits

To utilize your dental benefits, follow these steps:

1. Please read this Certificate and the Summary of Dental Plan Benefits carefully so you are familiar with your benefits, payment methods, and terms of This Plan.
2. Make an appointment with your Dentist and tell him or her that you have dental benefits with Delta Dental. If your Dentist is not familiar with This Plan or has any questions, have him or her contact Delta Dental by writing to Delta Dental, Attention: Customer Service, P.O. Box 9124, Farmington Hills, Michigan 48333, or calling the toll-free number at 866-827-3319.
3. After you receive your dental treatment, you or the dental office staff will file a claim form, completing the information portion with:

a. The Subscriber's full name and address

b. The Subscriber's Member ID number

c. The name and date of birth of the person receiving dental care

d. The Plan Sponsor's/Contractor's name and number Notice of Claim Forms

Delta Dental does not require special claim forms. However, most dental offices have claim forms available. A claim form is also available on our website, www.DeltaDentalNE.org. Participating Dentists will fill out and submit your dental Claims for you.

Mail Claims and completed information requests to:

Delta Dental
P.O. Box 9120
Farmington Hills, Michigan 48333

Pre-Treatment Estimate

A Pre-Treatment Estimate is not required to receive payment, but it allows Claims to be processed more efficiently and allows you to know what services may be covered before your Dentist provides them. You and your Dentist should review your Pre-Treatment Estimate Notice before treatment. Once treatment is complete, the dental office will submit a Claim to Delta Dental for payment.

Written Notice of Claim and Time of Payment

Because the amount of your Benefits is not conditioned on a Pre-Treatment Estimate decision by Delta Dental, all Claims under This Plan are post-service Claims. All Claims for Benefits must be filed with Delta Dental within one year of the date the services were completed. Written proof of loss must be given within 90 days after the date of loss or as soon as is reasonably possible.

Proof must be furnished as soon as possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required. Claims not filed within one year of the date the services were completed will be Denied if the services were performed by a Nonparticipating Dentist, or services that were not billable to the patient were performed by a Participating Dentist. Once a Claim is filed, Delta Dental will adjudicate it within 15 business days of receiving it. If there is not enough information to adjudicate your Claim, Delta Dental will notify you or your Dentist within 15 business days, or due to matters beyond the control of Delta Dental. The notice will

a) describe the information needed,

b) explain why it is needed,

c) request an extension of time in which to decide the Claim, and

d) inform you or your Dentist that the information must be received within 45 days or your Claim will be Denied if the services were performed by a Nonparticipating Dentist, or services not billable to the patient were performed by a Participating Dentist. You will receive a copy of any notice sent to your Dentist. Once Delta Dental receives the requested information, it has 30 days to adjudicate your Claim. If you or your Dentist does not supply the requested information, Delta Dental will Deny your Claim if the services were performed by a Nonparticipating Dentist, or Disallow your Claim if the services were performed by a Participating Dentist. Once Delta Dental adjudicates your Claim, it will notify you within five days.

Authorized Representative

You may appoint an authorized representative to deal with Delta Dental on your behalf with respect to any Claim you file or any review of a Denied Claim you wish to pursue (see the Claims Appeal Procedure section). You should contact your Plan Sponsor/Contractor, call Delta Dental's Customer Service department, toll-free, at 1-866-827-3319, or write them at P.O. Box 9124, Farmington Hills, Michigan, 48333, to request a form to designate the person you wish to appoint as your representative. Delta Dental will only recognize the person whom you have authorized on the last dated form filed with Delta Dental.

Questions and Assistance

Questions regarding your coverage should be directed to your Plan Sponsor/Contractor Delta Dental's Customer Service department, toll-free, at 1-866-827-3319. You may also write to Delta Dental's Customer Service department at

P.O. Box 9124, Farmington Hills, Michigan, 48333. When writing to Delta Dental, please include your name, the Plan Sponsor's/Contractor's name and group number, the Subscriber's Member ID number, and your daytime telephone number.

VI. How Payment is Made

Delta Dental shall make payments for Covered Services in accordance with the Summary of Dental Plan Benefits and this Certificate as selected by your employer or organization.

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 Maximum Amount Payable as determined by Delta Dental; (2) 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.

Delta Dental PPO℠ 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 PPOSM dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental PPOSM dentists is the lesser of: (1) The Delta Dental PPOSM Maximum Amount Payable as determined by Delta Dental; (2) The fee charged or accepted as payment in

full by the Delta Dental PPOSM 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. Delta Dental's allowable fee for a nonparticipating dentist is based on a fixed fee schedule determined to be reasonable by Delta Dental based on industry data.

Claim payments are sent directly to the Covered Person.

Orthodontics

If This Plan includes orthodontics it will be identified and paid as reflected in your Summary of Dental Plan Benefits.

Covered Services Requiring Multiple Visits

In the event a Covered Service requires more than one (1) visit with your Dentist, payment for the Covered Service will be rendered upon Completion Date.

VII. Benefit Categories

The Benefits covered by This Plan are set forth in your Summary of Dental Plan Benefits.

VIII. Exclusions and Limitations

Exclusions

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for these services may be your responsibility:

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Services received from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Medicaid or Medicare.
2. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations within the first 24 months of coverage under this plan.
3. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
4. Services completed or appliances completed before a person became eligible under This Plan. This exclusion does not apply to orthodontic treatment in progress (if a Covered Service).
5. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions, and relative analgesia.
6. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
7. Charges for hospitalization, laboratory tests, and histopathological examinations.
8. Charges for failure to keep a scheduled visit with the Dentist.
9. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
10. Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
11. Services or supplies, as determined by Delta Dental, which are specialized techniques.
12. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the supervision of a licensed dentist. Treatment rendered by any other licensed dental professional may be covered only as solely determined by the Plan Sponsor/Contractor and/or Delta Dental.
13. Occlusal procedures, including complex surgical occlusal procedures, increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
14. Complete or limited occlusal adjustments.
15. Services or supplies for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
16. Services or supplies received due to an act of war, declared or undeclared, or terrorism.
17. Services or supplies covered under a hospital, surgical/medical, or prescription drug program.
18. Services or supplies that are not within the categories of Benefits selected by the Plan Sponsor/Contractor and that are not covered under the terms of this Certificate.
19. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
20. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
21. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
22. Veneers.
23. Cone beam images.
24. Anatomical crown exposure.
25. Temporary anchorage devices.
26. Sinus Augmentation.
27. Brush Biopsy.
28. Extraoral X-rays.
29. Prefabricated crowns used as final restorations on permanent teeth.

30. Paste-type root canal fillings on permanent teeth.
31. Occlusal guards and all related services, including placement, repair, relines, or adjustments of occlusal guards.
32. Chemical curettage.
33. 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.
34. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
35. Intentional reimplantation.
36. Services associated with overdentures.
37. Metal bases on removable prostheses.
38. The replacement of teeth beyond the normal complement of teeth.
39. Personalization or characterization of any service or appliance.
40. Temporary crowns used for temporization during crown or bridge fabrication.
41. Interim removable or fixed prosthetic appliances (dentures or bridges).
42. Pediatric removable or fixed prosthetic appliances (dentures or bridges).
43. Posterior bridges in conjunction with partial dentures in the same arch.
44. Precision attachments and stress breakers.
45. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
46. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint.
47. Diagnostic photographs and cephalometric films, unless done for orthodontics and orthodontics are a Covered Service.
48. Myofunctional therapy.
49. Mounted case analyses.
50. Any and all taxes applicable to the services.
51. Athletic mouth guard, enamel microabrasion, and odontoplasty.
52. 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.
53. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
54. The completion of forms or submission of Claims.
55. Consultations, patient screening, or patient assessment..
56. Case presentation and office visits.
57. Local anesthesia.
58. Acid etching, cement bases, cavity liners, and bases or temporary fillings.
59. Infection control.
60. Temporary, interim, or provisional crowns.
61. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
62. Diagnostic casts.
63. Adjunctive diagnostic tests.
64. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.
65. Post-operative X-rays, when done following any completed service or procedure.
66. Periodontal charting.
67. Any substructure when done for inlays, onlays, and veneers.
68. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.
69. Placement or removal of a sedative filling, base, or liner used under a restoration.
70. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
71. Canal prep and fitting of preformed dowel and post.
72. Procedures designed to enable prosthetic or restorative services to be performed, such as crown lengthening.
73. Bacteriologic tests for determination of periodontal disease or pathological agents.
74. The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
75. Provisional splinting, temporary procedures or interim stabilization of teeth.
76. Guided tissue regeneration, and related procedures.
77. Surgical exposure of impacted or unerupted tooth for orthodontic reasons (surgical repositioning), except when orthodontic services are covered under the plan.
78. Oral surgery except for alveoplasty, vestibuloplasty, and simple and surgical extractions.
79. Cytology sample collection.
80. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.

81. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
82. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.
83. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
84. Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within 30 days of three or four quadrants of scaling and root planing or other periodontal treatment.
85. Full mouth debridement when done within 30 days of scaling and root planing.
86. Reline, rebase, or any adjustment or repair within six months of the delivery of a denture.
87. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
88. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period of time of performing panoramic and/or full mouth X-rays, as determined solely by Delta Dental.
89. Pulp vitality tests.
90. Delta Dental's processing policies for specific procedure codes may be applied and result in excluding payments. This includes but is not limited to time limits, frequency of procedures, and age limits.

Limitations

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for services or supplies that exceed these limitations may be your responsibility. All time limitations are measured from the applicable prior dates of services in our records with any Delta Dental Member Plan or, at the request of your Plan Sponsor/Contractor, any dental plan:

1. Bitewing X-rays are payable once per calendar year. Panoramic or full mouth X-rays are payable once in any five-year period.
2. Periapical X-rays are limited to 4 single x-rays per 12-month period. Occlusal X-Rays are limited to 2 series every 24 months.
3. Any combination of teeth cleanings (prophylaxes, full mouth debridement, scaling in the presence of inflammation, and periodontal maintenance procedures) are payable twice per calendar year. Full mouth debridement is payable once per lifetime..

   *Note: a prophylaxis performed on a person under the age of 14 will be considered as a child prophylaxis. A prophylaxis performed on a covered person age 14 or older will be considered as an adult prophylaxis.
4. Oral examinations and evaluations are only payable twice per calendar year, regardless of the Dentist's specialty.

*Note: Comprehensive oral evaluations will be considered 1 time per dental office, subject to the above limitation or limitations as stated in the Summary of Benefits. Any additional comprehensive oral evaluations performed by the same dental office will be considered a periodic oral evaluation, and allowed amounts determined accordingly, subject to any applicable limitations.

5. Preventive fluoride treatments are payable once per calendar year for people under age 19.
6. Space maintainers for posterior teeth are payable once per lifetime, per tooth for people under age 17. A distal shoe space maintainer is only payable for first permanent molars for people under age 9.
7. Sealants or Preventive Resin Restorations are payable once per lifetime for dependents under age 16 on permanent first and second molars.
8. Cast restorations (including jackets, crowns and onlays) are payable once in any five-year period per tooth.
9. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture.
10. Crown Repair is limited to 1 time per 12- month period per tooth.
11. Individual crowns over implants are payable at the prosthodontic benefit level.
12. Pre-fabricated or stainless steel crowns are limited to 1 time per 60- month period on primary teeth for dependent children through the age 18. Pre-fabricated resin crowns are covered for primary, anterior teeth only for dependent children through the age 18.
13. Alveoplasty and vestibuloplasty procedures are limited to 1 time per tooth/area per lifetime.
14. Reconstructive surgery benefits are limited to the following circumstances:
    - Incidental to or following surgery resulting from injury, illness, or other diseases of the involved part, or;
    - Performed on a covered dependent child because of congenital disease or anomaly which has resulted in functional defect as determined by the attending physician AND;
    - Procedures are dental reconstructive surgical procedures.
15. Endodontic Service limitations: Only one of the following procedures is a payable benefit 1 time per lifetime per tooth.

    Primary Teeth limitations:

    a. Pulpal Therapy

    b. Therapeutic Pulpotomy

    Permanent Teeth limitations:

a. Root Canal Therapy

16. Prosthodontic Services limitations:

    a. One complete upper and one complete lower denture, and any implant used to support a denture, are payable once in any five-year period.

    b. A removable partial denture, endosteal implant (other than to support a denture), or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.

    c. Implants, fixed bridges and removable partial dentures are not payable for people under age 16.

    d. A reline or the complete replacement of denture base material is payable once in any 24 month period per appliance.

    e. Denture adjustments are payable 2 times per 12-month period.

    f. Recementation of a fixed prosthetic is payable 1 time per 12- month period.

    g. Repairs, replacement of broken artificial teeth, replacement of broken clasp(s) are payable one time every 6 months when it is a permanent prosthetic appliance and more than 6 months has passed since the initial placement of the appliance.

    h. Single tooth implant body, abutment, and crown is payable 1 time per 5 - year period.

    i. Implant removal is payable once per lifetime per tooth or area.

    j. Implant maintenance is payable once per any twelve (12) month period.

17. Complex Surgical Periodontal Care limitations: Only one of the following procedures is a payable benefit 1 time per 3 year period per single permanent tooth or multiple permanent teeth in the same quadrant:

    a. Gingivectomy/gingivoplasty

    b. Gingival flap

    c. Apically positioned flap

    d. Osseous surgery

    e. Bone replacement graft

    f. Pedicle soft tissue graft

    g. Free soft tissue graft

    h. Subepithelial connective tissue graft

    i. Soft tissue allograft

    j. Combined connective tissue and double pedicle graft

    k. Distal/proximal wedge

18. Orthodontic Services limitations, if covered under your Plan pursuant to your Summary of Dental Plan Benefits:

    a. Orthodontic Services are payable for Members pursuant to the age limits specified in your Summary of Dental Plan Benefits.

    b. If the treatment plan terminates before completion for any reason, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.

    c. Upon written notification to Delta Dental and to the patient, a Dentist may terminate treatment for lack of patient interest and cooperation. In those cases, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.

19. Delta Dental's obligation for payment of Benefits ends on the last day of coverage. However, Delta Dental will make payment for Covered Services provided on or before the last day of coverage, as long as Delta Dental receives a Claim for those services within one year of the date of service.

20. When services in progress are interrupted and completed later by another Dentist, Delta Dental will review the Claim to determine the amount of payment, if any, to each Dentist.

21. Care terminated due to the death of a Member will be paid to the limit of Delta Dental's liability for the services completed or in progress.

22. Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.

    Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment.

    a. Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture.

    b. All-porcelain/ceramic bridges – Delta Dental will pay only the amount that it would pay for a conventional fixed bridge.

    c. Gold foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.

    d. Posterior stainless steel crowns with esthetic facings, veneers or coatings – Delta Dental will pay only the amount that it would pay for a conventional stainless steel crown.

23. Maximum Payment:

    All Benefits available under This Plan are subject to the Maximum Payment limitations set forth in your Summary of Dental Plan Benefits.

24. If a Deductible amount is stated in the Summary of Dental

Plan Benefits, Delta Dental will not pay for any services or supplies, in whole or in part, to which the Deductible applies until the Deductible amount is met.

25. Caries risk assessments are payable once in any 36 month period for members age 3 through 18.
26. One caries risk assessment is allowed within a twelve (12) month period when done by the same dentist/dental office
27. One caries risk assessment is allowed on the same date of service.
28. Amalgam and composite resin restorations are payable once in any 24 month period, regardless of the number or combination of restorations placed on a surface.
29. Recementation of a crown, onlay, inlay or bridge within six months of the seating date.
30. Root planing is payable once in any 24 month period.
31. Tissue conditioning is payable one time per arch in any 24 month period.
32. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
33. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
34. Delta Dental's processing policies for specific procedure codes may be applied and result in excluding payments. This includes but is not limited to time limits, frequency of procedures, and age limits.

IX. Coordination of Benefits Coordination of Benefits (COB)

The **Coordination of Benefits** (COB) provision applies when a person has health care coverage under more than one Plan, and determines the order in which individual Plans pay 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 consideration to what expenses others **Plans** may cover.
- The **Secondary plan** pays after the **Primary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

The order of benefit determinations rules govern the order in which each Plan will pay a claim for benefits.

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. Except as provided in the definition below, 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.

B. 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. 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 Member as a Subscriber will be primary over a plan that covers the Member as a dependent. However, please note that if the Member is a Medicare beneficiary, federal law may reverse this order.
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:

b) 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**.

c) 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, that **Plan** is primary.

ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, 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**.

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 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**; 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**.

d) 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.

e) For a dependent child who has coverage under either or both parents' plans and also has coverageas a dependent under a spouse's plan, the rule in Paragraph (5) applies.

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**. In addition, **this plan** will not pay more than it would have paid had it been the **Primary plan**.

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.

A Plan includes:

- Group and non-group insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care
- 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 motor vehicle contracts
- Medicare or any other federal governmental plan, as permitted by law

A 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
- Coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage in the bulleted lists above 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**.

When a **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**.

B. **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. In addition, any expense that a provider, either 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) 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**.

2) 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**.

3) 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.

4) 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.

C. **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 who have contracted with or are employed by the **Plan**, and which excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

D. **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.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When the **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 **plan** will calculate the benefits it would have paid in the absence of other dental 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 to equal the total **Allowable expense** when combined with the **Primary plan**. 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. Also, where the **Primary plan** is medical payments coverage under a motor vehicle policy, the secondary plan shall credit payments from the motor vehicle insurance policy to deductibles, copayments and coinsurance after discounts under the health plan.

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 the **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Delta Dental needs certain facts to apply these COB rules, and it has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person regarding the **Claim** being coordinated. Delta Dental need not tell or get the consent of any person to do this. Each person claiming **Benefits** under this **Plan** must give Delta Dental any facts it needs to pay the **Claim**.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, Delta Dental may pay that amount to the organization that made that payment.

That amount will then be treated as a benefit paid under this plan. Delta Dental 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 Delta Dental 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.

X. Reconsideration and Claims Appeal

Procedure Appeals

Grievance Procedures

This section contains important information about Delta Dental's procedures relating to Grievances and requests for Standard and Expedited Reviews, including reviews related to Adverse Benefit Determinations. Send your Grievance to the Delta Dental Appeals Unit at the following address:

Delta Dental of Nebraska
Professional Services Appeal and Grievances
PO Box 30416
Lansing, MI 48909

If you require assistance at any time, you have the right to contact the Nebraska Department of Insurance:

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

You are entitled to receive reasonable access to and copies of all records relevant to your Grievance, upon request and free of charge. This includes evidence or documentation used by Delta Dental in its determination. For Adverse Benefit Determinations, this includes the clinical rationale and review criteria used in making the determination.

Grievance: Standard Review

Within 180 days of receiving your Explanation of Benefits, you may file a Grievance under Standard Review on any relevant matter.

Delta Dental will provide you a written notice of the receipt of your Grievance within 3 business days. The notice will provide the name, phone number and address of the person coordinating the review. Neither you nor your authorized representative have the right to attend the review, however you may submit written comments, documents or other information in support of your Grievance.

The initial determination will not be given weight during the review process.

Delta Dental will provide a written decision to your Grievance within 15 business days of receiving it. If circumstances beyond our control prevent us from making a determination within this time period (except in the case of an Adverse Benefit Determination), it may take up to an additional 15 business days to make the determination. If this is necessary, Delta Dental will provide written notice on or before the 15th business day after receiving your Grievance.

Special Provisions Relating to Standard Review of Adverse Benefit Determination

In addition to the above "Grievance: Standard Review" provisions, Standard Reviews of Adverse Benefit Determinations will be evaluated by an appropriate clinical peer when reasonably necessary or when requested by the dental provider acting on behalf of the Covered Person. The clinical peer will not have been involved in the initial Adverse Benefit Determination. If the Standard Review of an Adverse Benefit Determination does not resolve the matter, you, your authorized representative, or your dental provider – if allowed under applicable law – may submit another Grievance to Delta Dental.

Grievance: Expedited Review

If your Grievance involves a matter that requires Expedited Review, you, your authorized representative, or the dental provider acting on your behalf may request a review of your Grievance.

Requests may be made either in writing or orally. All necessary information, including Delta Dental's decision, will be submitted by the most expeditious method available. Delta Dental will make a decision and notify you, your authorized representative, or the dental provider acting on your behalf no more than 72 hours after the request for Expedited Review is received. If the initial decision notification is not provided in writing, Delta Dental will provide written confirmation of our decision within 2 business days after providing initial notification of our decision.

Expedited Review of Grievances that result in an Adverse Benefit Determination will be evaluated by an appropriate clinical peer. The clinical peer will not have been involved in the initial Adverse Benefit Determination. Delta Dental will provide reasonable access to the clinical peer within 1 business day after receipt of the request for Expedited Review of the Grievance.

If your request for Expedited Review is a concurrent care review determination, your coverage will continue for the dental care service until Delta Dental notifies you of its decision.

If the Expedited Review does not resolve the matter, you, your authorized representative, or your dental provider may submit another Grievance to Delta Dental.

Note: Delta Dental is not required to provide an Expedited Review for retrospective Adverse Benefit Determinations.

Written Decision

When a decision is issued by Delta Dental in response to a Standard Review or Expedited Review Grievance, including a Grievance related to an Adverse Benefit Determination, Delta Dental's written notice to you shall contain:

a) the names, titles and credentials of the person or persons reviewing the Grievance;

b) a statement of the reviewer's understanding of the Grievance;

c) the decision and the basis for such decision in detail sufficient to allow you to make further responses to Delta Dental's position;

d) evidence or documentation used in making the decision;

e) in cases of Grievances involving Adverse Benefit Determinations, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the decision; and

f) notice of your right to contact the Nebraska Department of Insurance, along with the telephone number and address.

XI. Termination of Coverage

Your Delta Dental coverage may automatically terminate:

- When the Plan Sponsor/Contractor advises Delta Dental to terminate your coverage.
- On the first day of the month for which the Plan Sponsor/Contractor has failed to pay Delta Dental.
- For fraud or misrepresentation in the submission of any Claim.
- For your Dependent, when they no longer qualify as a Dependent.
- For any other reason stated in the contract between Delta Dental and the Plan Sponsor/Contractor.
- On the date the Group terminates the contract.

Delta Dental will not continue eligibility for any person covered under This Plan beyond the termination date requested by the Plan Sponsor/Contractor. A person whose eligibility is terminated may not continue group coverage under this Certificate, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 or comparable, non-preempted state law ("COBRA").

XII. Continuation of Coverage

If the Plan Sponsor/Contractor is required to comply with COBRA and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and your dental coverage would otherwise end, you and your Dependents may have the right to continue that coverage at your expense.

When is Plan Continuation Coverage Available?

Continuation coverage is available if your coverage or a covered Dependent's coverage would end because:

1. Your employment, if applicable, ends for any reason other than your gross misconduct.
2. You do not qualify as a Subscriber as set forth in your Summary of Dental Plan Benefits.
3. You are divorced or legally separated.
4. You die.
5. Your Dependent is no longer a Dependent.
6. You become enrolled in Medicare (if applicable).
7. You are called to active duty in the armed forces of the United States.

If you believe you are entitled to continuation coverage, you should contact the Plan Sponsor/Contractor to receive the appropriate documentation required under the Employee Retirement Income Security Act of 1974 ("ERISA").

XIII. General Conditions

Assignment

Services and Benefits are for the personal benefit of Members and cannot be transferred or assigned, other than to pay Participating Dentists directly.

Subrogation and Right of Reimbursement

To the extent that This Plan provides or pays Benefits for Covered Services, Delta Dental is subrogated to any right you and/or your Dependent has to recover from another party or entity, including but not limited to, that party's insurer, or any other insurer that you or your Dependent may have, which would have been the primary payer if not for the payments made by Delta Dental. This includes but is not limited to, automobile, home, and other liability insurers, as well as any other group health plans.

To the extent that Delta Dental has a subrogation right, you and/or your Dependent must:

1. Provide Delta Dental with any information necessary to identify any other person, entity or plan that may be obligated to provide payments or benefits for the Covered Services that were paid for by Delta Dental,
2. Cooperate fully in Delta Dental's exercise of its right to subrogation and reimbursement,
3. Not do anything to prejudice those rights (such as settling a claim against another party without notifying Delta Dental, or not including Delta Dental as a co-payee of any settlement amount),
4. Sign any document that Delta Dental determines is relevant to protect Delta Dental's subrogation and reimbursement rights, and
5. Provide relevant information when requested.

The term "information" includes any documents, insurance policies, and police or other investigative reports, as well as any other facts that may reasonably be requested to help Delta Dental enforce its rights. Failure by you or your Dependent to cooperate with Delta Dental may result, at the discretion of Delta Dental, in a reduction of future benefit payments available to you or your Dependent under This Plan of an amount up to the aggregate amount paid by Delta Dental that was subject to Delta Dental's equitable lien, but for which Delta Dental was not reimbursed.

Obtaining and Releasing Information

While you and/or your Dependent(s) are enrolled in This Plan, you and/or your Dependent(s) agree to provide Delta Dental with any information it needs to process Claims and administer Benefits for you and/or your Dependent(s). This includes allowing Delta Dental access to your dental records.

Dentist-Patient Relationship

Members are free to choose any Dentist. Each Dentist is solely responsible for the treatment and/or dental advice provided to the Member, and Delta Dental does not have any liability resulting therefrom.

Loss of Eligibility During Treatment

If a Member loses eligibility while receiving dental treatment, only Covered Services received while that person was covered under This Plan will be payable.

Certain services begun before the loss of eligibility may be covered if they are completed within 60 days from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. The difference between Delta Dental's payment and the total fee for those services is your responsibility. This provision does not apply to orthodontics if covered under This Plan.

Late Claims Submission

Delta Dental will make no payment for services or supplies if a Claim for such has not been received by Delta Dental within one

year following the date the services or supplies were completed, except in the absence of legal capacity. In the event that a Participating Provider submits a Claim more than one year from the date of service, Delta Dental will Disallow the Claim. However, in the event that a Nonparticipating Provider submits a Claim more than one year from the date of service, Delta Dental will Deny the Claim and you may be responsible for the full amount.

Change of Certificate or Contract

No changes to this Certificate, your Summary of Dental Plan Benefits, or the underlying contract are valid unless Delta Dental approves them in writing.

Actions

You cannot bring an action on a legal claim arising out of or related to this Certificate unless you have provided at least 60 days' written notice to Delta Dental, unless prohibited by applicable state law. In addition, no legal action shall be brought to recover on the policy prior to the expiration of 60 days after written proof of loss has been furnished. No such action shall be brought after 3 years from the time written proof of loss is required to be furnished. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude you from seeking a judicial decision or pursuing other available legal remedies.

Change of Status

You must notify Delta Dental, within 31 days through the Plan Sponsor/Contractor, of any event that changes the status of a Dependent. Events that can affect the status of a Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.

Governing Law

This Certificate and the underlying group contract will be governed by and interpreted under the laws of the state of Nebraska.

Right of Recovery Due to Fraud

If Delta Dental pays for services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a Claim that contains false or misrepresented information, or pays a Claim that is determined to be fraudulent due to your acts or acts of your Dependents, it may recover that payment from you or your Dependents. Delta Dental may recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you or your Dependents.

There must be clear documented evidence of an overpayment within Delta Dental's files showing the overpayment was clearly erroneous. The Member will be notified within 6 months of the error, and the claim used to adjust the overpayment must be made no later than 3 years after the date of the error. Delta Dental will provide an explanation of the payment recovery at the time the deduction is made.

Legally Mandated Benefits

If any applicable law requires broader coverage or more favorable treatment for you or your Dependents than is provided by this Certificate, that law shall control over the language of this Certificate.

Any person intending to deceive an insurer, who knowingly submits an application or files a Claim containing a false or misleading statement, is guilty of insurance fraud.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call our toll-free hotline. We only accept anti-fraud calls at this number.

ANTI-FRAUD TOLL-FREE HOTLINE:
612-224-3277