



DELTA DENTAL PREMIER®

BENEFITS CERTIFICATE

STATE OF IOWA

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SUMMARY OF PAYMENT

UNDERSTANDING YOUR PAYMENT OBLIGATIONS

■ USING THE SUMMARY OF PAYMENT CHART

The information on this page describes how to use the SUMMARY OF PAYMENT chart which summarizes your benefits and payment obligations. This chart is found on the next page.

For a detailed description of specific benefits and benefit limitations, see SECTION 1: BENEFITS. For additional payment information, see SECTION 4: YOUR PAYMENT OBLIGATIONS.

If your deductible, coinsurance, benefit period maximum, or lifetime maximum:

- *Is the same for all benefit categories*, it is listed in the ALL BENEFIT CATEGORIES row. However, if a specific benefit category or individual benefit has a unique deductible, coinsurance, benefit period maximum, or lifetime maximum, it will appear directly across from that benefit.
- *differs between benefit categories*, the deductible, coinsurance, benefit period maximum, or lifetime maximum for each category appears across from the specific category heading and applies to all benefits listed in that benefit category. If a specific benefit has a unique deductible, coinsurance, benefit period maximum, or lifetime maximum, it will appear directly across from that benefit.

If any of the above payment categories - deductible, coinsurance, benefit period maximum, or lifetime maximum - do not apply to you, the corresponding column will appear blank.

■ UNDERSTANDING PAYMENT VOCABULARY

The following amounts are shown on the SUMMARY OF PAYMENT chart on the next page.

SUMMARY OF PAYMENT

Coinsurance. The amount, calculated using a fixed percentage, you pay each time you receive covered services.

Benefit Period Maximum. The maximum benefit each member is eligible to receive for certain covered services in a benefit period. The benefit period maximum is reached from claims settled under this coverage in a benefit period.

SUMMARY OF BENEFITS AND PAYMENT

The information on this page summarizes your benefits and payment obligations. For a detailed description of specific benefits and benefit limitations, see the IMPORTANT INFORMATION and BENEFITS sections of this certificate.

If a dollar amount for a benefit period maximum is shown at the top of the chart and applies to a benefit category, “Yes” will be indicated across from that category. If the information does not apply it will indicate “Waived” or be left blank. If there is unique information for a specific benefit it will appear across from that benefit.

Delta Dental Premier®	DEDUCTIBLE	COINSURANCE	BENEFIT PERIOD MAX	LIFETIME MAX
Benefit Categories	None		\$1,500	\$1,500
Check-Ups and Teeth Cleaning (Diagnostic and Preventive Services) 1. Dental Cleaning 2. Oral Evaluation 3. Fluoride Applications 4. X-rays			Yes	
Cavity Repair and Tooth Extractions (Routine and Restorative Services) 1. Emergency Treatment 2. General Anesthesia/Sedation 3. Restoration of Decayed or Fractured Teeth 4. Limited Occlusal Adjustment 5. Routine Oral Surgery 6. Sealant Applications * * (\$120 Lifetime Maximum) 7. Space Maintainers		20%	Yes	

	DEDUCTIBLE	COINSURANCE	BENEFIT PERIOD MAX	LIFETIME MAX
Root Canals (Endodontic Services) <ol style="list-style-type: none"> 1. Apicoectomy 2. Direct Pulp Cap 3. Pulpotomy 4. Retrograde Fillings 5. Root Canal Therapy 		50%	Yes	
Gum and Bone Diseases (Periodontal Services) <ol style="list-style-type: none"> 1. Conservative Procedures 2. Complex Procedures 3. Maintenance Therapy 		50%	Yes	
High Cost Restorations (Cast Restorations) <ol style="list-style-type: none"> 1. Cast Restorations <ol style="list-style-type: none"> a. Crowns b. Inlays c. Onlays d. Posts and Cores 		50%	Yes	
Dentures and Bridges (Prosthetics) <ol style="list-style-type: none"> 1. Bridges 2. Dentures 		50%	Yes	
Straighter Teeth (Orthodontics)		50%	Waived	Yes

Benefit Period Maximum:

Benefit Period Maximum is the maximum benefit each member is eligible to receive for certain covered services during a benefit period. Your overall benefit period maximum is: \$1,500 per member. This benefit period maximum amount is accumulated from covered benefits received from a combination of *all* benefit categories except STRAIGHTER TEETH.

Please note: There is a limit of two visits per member per benefit period for Benefit Category: **CHECK-UPS AND TEETH CLEANING.**

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IMPORTANT INFORMATION

Your Delta Dental Premier coverage is administered by Delta Dental of Iowa. By encouraging preventive care, this dental program is designed to help contain dental costs. The key component of Delta Dental Premier program is our panel of *participating dentists*, hereafter referred to as *Delta Dental dentists*. You may seek care from almost any dentist you wish. However, there are advantages when you receive services from Delta Dental dentists.

USING THE DELTA DENTAL PROGRAM

■ WHAT YOU SHOULD KNOW ABOUT DELTA DENTAL DENTISTS

When you receive services from dentists who participate with Delta Dental of Iowa, all of the following statements are true:

- Delta Dental dentists agree to accept Delta Dental's payment arrangements, which may result in savings. See SECTION 4: YOUR PAYMENT OBLIGATIONS.
- Delta Dental dentists agree to file claims for you.
- We settle claims directly with Delta Dental dentists. You are responsible for any coinsurance amounts you may owe. See SECTION 4: YOUR PAYMENT OBLIGATIONS.
- Delta Dental dentists agree to handle the notification program for you. See SECTION 3: THE NOTIFICATION PROGRAM.

It is most often to your financial advantage to receive services from Delta Dental dentists.

IMPORTANT INFORMATION

WHAT YOU SHOULD KNOW ABOUT NONPARTICIPATING DENTISTS When you receive services from nonparticipating dentists, you will not receive any of the advantages that our contracts with Delta Dental dentists offer. As a result, when you receive services from nonparticipating dentists, all of the following statements are true:

- We do not have contracts with nonparticipating dentist and they do not agree to accept Delta Dental's payment arrangements. This means you are responsible for any difference between the covered charge and the Delta allowance. See SECTION 4: YOUR PAYMENT OBLIGATIONS.
- Nonparticipating dentist are not responsible for filing your claims. See SECTION 5: FILING CLAIMS.
- We settle claims with you, not nonparticipating dentists. You are responsible for paying your dentist in full, including any coinsurance, and non-approved charges you may owe. See SECTION 4: YOUR PAYMENT OBLIGATIONS.
- Nonparticipating dentist do not agree to handle the notification program for you. See SECTION 3: THE NOTIFICATION PROGRAM.
- Nonparticipating dentist may charge for "infection control," which includes the costs for services and supplies associated with sterilization procedures. You are responsible for any extra charges billed by a nonparticipating dentist for "infection control." (All dentists are legally required to follow certain guidelines to protect their patients and staff from exposure to infection. However, Delta Dental dentists incorporate these costs into their normal fees and do not charge an additional fee for "infection control.")

UNDERSTANDING THIS CERTIFICATE

■ WHAT YOU SHOULD KNOW ABOUT THIS COVERAGE

It's important that you understand all parts of this certificate in order to get the most out of your coverage. To help make the information easier to understand, we use the words *you* and *your* to refer to you and your family members eligible for coverage under this certificate. *We*, *us*, and *our* refer to Delta Dental of Iowa.

IMPORTANT INFORMATION

■ QUESTIONS WE ASK WHEN YOU RECEIVE DENTAL CARE

You should understand that information in one section may be related to other sections. To help you find crucial information, we direct you within the text to appropriate sections whenever possible. Even though a procedure may appear in SECTION 1: BENEFITS, you should note that before you are eligible to receive benefits, we first answer all of the following questions:

Is the Procedure Dentally Necessary? All of the following must be true for a procedure to be considered dentally necessary:

- The diagnosis is proper.
- The treatment is necessary to preserve or restore the form and the function of the tooth or teeth and the health of the gums, bone, and other tissues supporting the teeth.

Is the Procedure Dentally Appropriate? All of the following must be true for a procedure to be considered dentally appropriate:

- The treatment is the most appropriate procedure for your individual circumstances.
- The treatment is consistent with and meets professionally recognized standards of dental care and complies with criteria adopted by us.
- The treatment is not more costly than alternative procedures that would be equally effective for the treatment or maintenance of your teeth and their supporting structures. If you receive alternative services other than the least costly, you are responsible for paying the difference.

Is the Procedure Subject to Contract Limitations? Contract limitations refer to amounts that are your liability based on your contractual obligations with us. Examples of contract limitations include all of the following:

- Amounts for procedures that are not dentally necessary or dentally appropriate.
- Amounts for procedures that are not covered by this certificate. See SECTION 2: SERVICES NOT COVERED.

IMPORTANT INFORMATION

- Amounts for procedures that have limitations associated with them. For example, teeth cleaning is covered once every six consecutive months. More frequent teeth cleaning is not a benefit even if your dentist verifies that it is dentally necessary and dentally appropriate. See SECTION 1: BENEFITS for a description of covered procedures and limitations associated with certain procedures.
 - Amounts for procedures that have reached contract maximums. See the SUMMARY OF PAYMENT chart at the beginning of this certificate.
- Any difference between the covered charge and the Maximum Plan Allowance (Delta Allowance). **Please note:** This only applies if you receive services from a nonparticipating dentist.

■ OUR PAYMENT POLICY

Our policy is to send our payment for treatment after it is completed-not before. For example, we will send our payment for:

- a crown when it is seated.

■ INTERPRETING THIS CERTIFICATE

We will interpret the provisions of this coverage and determine the answer to all questions that arise under it. We have the administrative discretion to determine whether you meet our written eligibility requirements, or to interpret any other term in this certificate. If any benefit in this certificate is subject to a determination of dental necessity and dental appropriateness, we will make that factual determination. Our interpretations and determinations are final and conclusive.

In order for us to properly administer your benefits, there are certain rules you must follow. Different rules appear in different sections of your certificate. We urge you to become familiar with the entire certificate.

- **HELPING WHEN YOU HAVE QUESTIONS** If you have any questions after reading this certificate, please call us. For your convenience, we have listed our toll-free number on the back cover of this certificate.

SECTION 1: BENEFITS

CHECK-UPS AND TEETH CLEANING

■ DIAGNOSTIC AND PREVENTIVE SERVICES

1. **Dental Cleaning (Prophylaxis).**

Removing plaque, tartar (calculus), and stain from teeth.

Limitation: Dental cleaning is a benefit only twice per benefit period.

2. **Oral Evaluation.**

Limitation: This evaluation is a benefit only twice per benefit period.

3. **Topical Fluoride Applications.**

Limitation: Topical fluoride is a benefit only for unmarried dependent children under age 19 once every 12 consecutive months.

4. **X-Rays**

a. **Bitewing X-Rays.**

Limitation: These x-rays are a benefit only once every 12 consecutive months.

b. **Full-Mouth X-Rays.**

Full-mouth x-rays include a combination of individual x-rays such as periapical, bitewing or occlusal taken by a dentist on the same service date. A panoramic x-ray is a benefit if full-mouth x-rays have not been performed within 3 consecutive years of the panoramic x-ray.

Limitation: These x-rays are a benefit only once every three consecutive years.

c. **Occlusal and Extraoral X-Rays.**

Limitation: These x-rays are a benefit only once every 12 consecutive months.

d. **Periapical X-Rays.**

Limitation: These x-rays are a benefit only once every 12 consecutive years.

CAVITY REPAIR AND TOOTH EXTRACTIONS

■ ROUTINE AND RESTORATIVE SERVICES

1. **Emergency Treatment (Palliative Treatment).**

Treatment to relieve pain or infection of dental origin.

2. **General Anesthesia/Sedation.**

Limitation: General anesthesia and intravenous sedation are benefits only when provided in conjunction with covered oral surgery and when billed by the operating dentist.

3. **Restoration of Decayed or Fractured Teeth.**

Pre-formed or stainless steel restorations and restorations such as silver (amalgam) fillings, and tooth-colored (composite) fillings.

Limitation: If you choose a tooth-colored filling to restore back (posterior) teeth, benefits are limited to the amount paid for a silver filling. You are responsible for paying the difference.

4. **Limited Occlusal Adjustment.**

Reshaping the biting surfaces of one or more teeth.

Limitation: You are not covered for Complete Occlusal Adjustment, a more complex procedure which requires several appointments and is intended to revise or alter the functional relationships between upper and lower teeth.

5. **Routine Oral Surgery.**

Including removal of teeth, and other surgical services to the teeth or immediate surrounding hard and soft tissues that are being performed due to disease, pathology, or dysfunction of dental origin.

6. **Sealant Applications.**

Filling decay-prone areas of the chewing surface of molars. *Limitation:* Sealant applications are a benefit:

- for eligible, dependent children under age 15.
- once per permanent first and second molars in a lifetime.
- up to \$120 in a lifetime.

Sealants for primary teeth, wisdom teeth, or teeth that have already been treated with a restoration are not a benefit.

7. **Space Maintainers** for missing back teeth.

Limitation: Space maintainers are a benefit only for eligible dependent children under age 14.

ROOT CANALS

■ ENDODONTIC SERVICES

1. **Apicoectomy/Periradicular Surgery.**
Surgery to repair a damaged root as part of root canal therapy or to correct a previous root canal.
2. **Direct Pulp Cap.**
Covering exposed pulp with a dressing or cement to protect it and promote healing and repair. *Treatment of pulp that is not exposed (indirect pulp cap) is not a benefit.*
3. **Pulpotomy.**
Removing the coronal portion of the pulp as part of root canal therapy. When performed on a baby (primary) tooth, pulpotomy is the only procedure required for root canal therapy.
4. **Retrograde Fillings.**
Sealing the root canal by preparing and filling it from the root end of the tooth.
5. **Root Canal Therapy.**
Treating an infected or injured pulp to retain tooth function. This procedure generally involves removal of the pulp and replacement with an inert filling material.

GUM AND BONE DISEASES

■ PERIODONTAL SERVICES

Please note: Procedures in this category should receive our review before they are performed. See SECTION 3: THE NOTIFICATION PROGRAM.

1. **Conservative (Non-Surgical) Periodontal Procedures (Root Planing and Scaling).**

Removing contaminants such as bacterial plaque and tartar (calculus) from a tooth root to prevent or treat disease of the gum tissues and bone which support it.

Limitation: Conservative periodontal procedures are a benefit only once every 24 consecutive months for each quadrant.

2. **Complex Periodontal Procedures**

Various surgical interventions designed to repair and regenerate gum and bone tissues that support the teeth.

Limitation: Complex periodontal procedures are a benefit only once per benefit period for each quadrant of the mouth for natural teeth only.

Note: A quadrant is one of the four equal sections of the mouth into which the jaws can be divided and represents four or more contiguous teeth or bounded teeth spaces.

3. **Periodontal Maintenance Therapy.**

Include various maintenance services such as pocket depth measurements, dental cleaning (oral prophylaxis), removal of stain, and root planing and scaling. *Limitation:* This procedure may follow conservative or complex periodontal therapy. When this procedure immediately follows complex or conservative periodontal therapy, benefits are available up to four times per benefit period and twice per benefit period thereafter. This procedure replaces the dental cleaning benefit (prophylaxis) described under Check-ups and Teeth Cleaning earlier in this section.

HIGH COST RESTORATIONS

■ CAST RESTORATIONS

Procedures in this category are available once every five consecutive years beginning from the date the cast restoration is cemented in place.

1. Cast Restorations for Complicated Tooth Decay or Fracture

Restoring a tooth with a cast filling (including local anesthesia) when the tooth cannot be restored with a silver (amalgam) or tooth-colored (composite) filling.

- a. **Crowns.** Restoring form and function by covering and replacing the visible part of the tooth with a precious metal, porcelain fused to metal, or porcelain crown. *Crowns placed for the primary purpose of periodontal splinting, cosmetics, altering vertical dimension, restoring your bite (occlusion), or restoring a tooth due to attrition and abrasion are not a benefit. Limitation:* Crowns are a benefit only if the tooth cannot be restored with a routine filling. Crowns which are supported by surgically placed dental implants will be limited to the amount paid for conventional, natural tooth supported crown. **Dental implants are not a covered benefit.**
- b. **Inlays.** Restoring a tooth with a cast metallic or porcelain filling.
Limitation: Inlay benefits are limited to the amount paid for a silver (amalgam) filling. See *Restoration of Decayed and Fractured Teeth*, described under *Cavity Repair and Tooth Extraction* earlier in this section.
- c. **Onlays.** Replacing one or more missing or damaged biting cusps of a tooth with a cast restoration.
- d. **Posts and Cores.** Preparing a tooth for a cast restoration after a root canal when there is insufficient strength and retention.
- e. **Recementation of Cast Restorations**
Limitation: Benefits are limited to once every 12 consecutive months after 6 months have elapsed since initial placement.

DENTURES AND BRIDGES

PROSTHETICS

Please note: Dentures and bridges (prosthetics) are a benefit once every 5 consecutive years.

Bridges

Replacing missing permanent teeth with a dental prosthesis that is cemented in place and can only be removed by a dentist. Also covered are bridge repairs.

Limitation: Bridges which are supported by dental implants are limited to the amount paid for a bridge supported by natural teeth. **Dental implants are not a covered benefit.**

Dentures (Complete and Partial)

Replacing missing permanent teeth with a dental prosthesis that is removable. Denture repair and relining are also covered.

Limitation: Dentures which are supported by surgically placed dental implants will be limited to the amount paid for a conventional, natural-teeth-supported prosthesis. **Dental implants are not a covered benefit.**

Denture Adjustments

Limitations: Denture Adjustments will be limited to two per denture per benefit period after 6 months has elapsed since initial placement.

Tissue Conditioning

Limitation: Tissue conditioning will be limited to two per denture every 36 consecutive months.

STRAIGHTER TEETH ORTHODONTICS

Orthodontics. Services for proper alignment of teeth.

Limitation: Orthodontic therapy or treatment is a benefit only for unmarried, dependent children under age 19.

When an orthodontic treatment plan is established, Delta Dental of Iowa will calculate an initial payment at the time the banding takes place. The balance of the allowed fee will then be divided into quarterly payments over the course of treatment, providing coverage still exists.

If orthodontic treatment is stopped for any reason before it is completed, Delta Dental of Iowa will pay only for covered services and supplies actually received. No benefits are available for charges made after treatment stops or after the termination of coverage.

Delta Dental of Iowa payment for treatment in progress extends only to the months of treatment received while covered under the plan. Delta Dental of Iowa will determine the months eligible for coverage.

Diagnostic Cast

Limitation: Diagnostic cast is a benefit only in conjunction with orthodontic treatment.

SECTION 2: SERVICES NOT COVERED

This Delta Dental coverage *does not* provide benefits for dental treatment listed in this section. *Please note: Even if the treatment is not specifically listed as an exclusion, it may not be covered under this certificate. Call us if you are unsure if a certain service is covered.*

PROGRAM EXCLUSIONS

Anesthesia or Analgesia. You are not covered for local anesthesia or nitrous oxide (relative analgesia) when billed separately from the related procedure. This exclusion does not apply to general anesthesia or intravenous sedation administered in connection with covered oral surgery as described in SECTION 1: BENEFITS.

Broken Appointments. You are not covered for any fees charged by your dental office because of broken appointments.

Complete Occlusal Adjustment. You are not covered for services or supplies used for revision or alteration of the functional relationships between upper and lower teeth. However, you are covered for limited occlusal adjustment, a less complex procedure to reshape the biting surfaces of one or more teeth.

Complications of a Non-Covered Procedure. You are not covered for complications of a non-covered procedure.

Congenital Deformities. You are not covered for services or supplies to correct congenital deformities, such as a cleft palate.

Controlled Release Device. You are not covered for services or supplies used for the controlled release of therapeutic agents into diseased crevices around your teeth.

Cosmetic in Nature. You are not covered for services or supplies which have the primary purpose of improving the appearance of your teeth, rather than restoring or improving dental form or function.

SECTION 2: SERVICES NOT COVERED

Certificate Termination. Whether or not we have approved a treatment plan, you are not covered for treatment received after the coverage termination date of this certificate.

Crowns Not Meant to Restore Form and Function. You are not covered for crowns that are not meant to restore form and function of a tooth, including crowns placed for the primary purpose of periodontal splinting, cosmetics, altering vertical dimension, restoring your bite (occlusion), or restoring a tooth due to attrition and abrasion.

Desensitization Material. You are not covered for desensitization materials or their application.

Drugs. You are not covered for prescription and non-prescription drugs or medicines.

Effective Date. You are not covered for services or supplies received before the effective date of coverage under this program.

Experimental or Investigative. You are not covered for services or supplies that are considered experimental, investigative or have a poor prognosis. Peer reviewed outcomes data from clinical trials, Food and Drug Administration regulatory status, and established governmental and professional guidelines will be used in this determination.

Government Programs. You are not covered for services or supplies when you are entitled to claim benefits from governmental programs (except Medicaid).

Guided Tissue Regeneration. You are not covered for services or supplies to encourage regeneration of lost periodontal structures.

Implants. You are not covered for any dental implants which are surgically placed in the jawbone or the attachment of any device to a surgically placed implant in the jawbone except as stated under Crowns, Bridges, and Dentures.

Incomplete Services. You are not covered for dental services that have not been completed.

Indirect Pulp Caps. You are not covered for indirect pulp caps.

SECTION 2: SERVICES NOT COVERED

Infection Control. You are not covered for separate charges for "infection control," which includes the costs for services and supplies associated with sterilization procedures. Delta Dental dentists incorporate these costs into their normal fees and will not charge an additional fee for "infection control."

Lost or Stolen Appliances. You are not covered for services or supplies required to replace lost or stolen dental appliances.

Medical Services or Supplies. You are not covered for services or supplies which are medical in nature, including dental services performed in a hospital, treatment of fractures and dislocations, treatment of cysts and malignancies, and accidental injuries.

Military Service. You are not covered for services or supplies which are required to treat an illness or injury received while you are on active status in the military services.

Orthodontics for Adult. You are not covered for adult orthodontics.

Payment Responsibility. You are not covered for services or supplies when someone else has the legal obligation to pay for your care and when in the absence of this program, you would not be charged.

Periodontal Appliances. You are not covered for services or supplies for periodontal appliances (bite guards) to reduce bite (occlusal) trauma due to tooth grinding or jaw clenching.

Periodontal Splinting. You are not covered for services or supplies used for the primary purpose of reducing tooth mobility, including crown-type restorations.

Provisional Crowns, Bridges or Dentures. You are not covered for services or supplies for provisional crowns, bridges or dentures.

Repair or Replacement of Orthodontic Appliances. You are not covered for services or supplies required to repair or replace any orthodontic appliance.

Sealants for Primary Teeth, Wisdom Teeth, or Restored Teeth. You are not covered for sealants for primary teeth, wisdom teeth, or teeth that have already been treated with a restoration.

Services Provided in Other Than Office Setting

You are not covered for services provided in other than a dental office setting.

SECTION 2: SERVICES NOT COVERED

Specialized Services

You are not covered for specialized, personalized, elective materials and techniques or technology which are not reasonably necessary for the diagnosis or treatment of dental disease or dysfunction. Specialized services represent enhancements to other services and are considered optional.

Temporary or Interim Procedures

You are not covered for temporary or interim procedures.

Temporomandibular Joint Dysfunction (TMD)

You are not covered for expenses incurred for diagnostic x-rays, appliances, restorations or surgery in connection with Temporomandibular Joint Dysfunction (TMD) or myofunctional therapy.

Treatment By Other Than A Licensed Dentist

You are not covered for services or treatment performed by other than a licensed dentist or his or her employees

Unerupted Teeth. You are not covered for the prophylactic removal of unerupted teeth (asymptomatic and nonpathological). This means we will not pay for the removal of any tooth that is not visible and not causing harm.

Workers' Compensation. You are not covered for services or supplies that are or could have been compensated under Workers' Compensation laws, including services or supplies applied toward satisfaction of any deductible under your employer's Workers' Compensation coverage.

SECTION 3: THE NOTIFICATION PROGRAM

This section explains the notification program you or your Delta Dental dentist should follow *before you receive certain benefits available under this certificate. This program is the checks and balances of your dental coverage. It helps:*

- us determine that services are dentally necessary and dentally appropriate;
 - confirm the benefits of your certificate.
-

■ THE APPROVAL

The purpose of the notification program is to help control the cost of your benefits - not to keep you from receiving dentally necessary and dentally appropriate treatment.

You should notify us before you receive the following benefits:

Gum and Bone Diseases

Our review is based on the treatment plan submitted by your dentist.

■ THE TREATMENT PLAN

A treatment plan describes the treatment your dentist has recommended for you and helps us determine if the procedure is a benefit of your coverage as well as dentally necessary and dentally appropriate.

When to Submit a Treatment Plan.

You will need to file a treatment plan only if your dentist is nonparticipating - Delta Dental dentists agree to file for you.

A complete treatment plan includes the plan of treatment and x-rays. Please send the x-ray within 15 working days of receipt of the proposed treatment plan.

SECTION 3: THE NOTIFICATION PROGRAM

Where to Send a Treatment Plan. Submit the proposed treatment plan, along with x-rays and supporting information to:

Delta Dental of Iowa
P.O. Box 919
Ankeny, IA 50021-0919

■ THE TREATMENT PLAN REVIEW

Once we receive the treatment plan and proper documentation, we will let you and your dentist know if the treatment plan is approved within 15 working days. We will take one of the following three actions when we receive your treatment plan:

- *accept* it as submitted.
- *recommend an alternative benefit.* If we ask you to receive an independent diagnosis from a dentist of our choice, we will pay for the exam.
- *deny the treatment plan* because:
 - the procedure is not a benefit of your program;
 - you did not receive an independent exam after we asked you to; or
 - the procedure is not dentally necessary and dentally appropriate.

Appeal. If we deny a treatment plan, you can resubmit it with additional documentation and ask us, in writing, to reconsider. If necessary, we will ask you to receive an independent diagnosis from an independent dentist of our choice—we will pay for the exam.

Please note: Although we may approve a treatment plan, we are not liable for the actual treatment you receive from your dentist.

SECTION 4: YOUR PAYMENT OBLIGATIONS

UNDERSTANDING PAYMENT VOCABULARY

■ **BENEFIT PERIOD**

A benefit period is the same as a calendar year. It begins on the day your coverage goes into effect and starts over each January 1. This is true for as long as you have coverage.

The benefit period is important for calculating your benefit period maximum, if applicable.

■ **BILLED CHARGE**

The billed charge is the amount a dentist bills for a specific dental procedure.

■ **COVERED CHARGE**

The covered charge is the amount a dentist bills for a dental procedure *that is a benefit of your certificate*.

Maximum Plan Allowance (Delta Allowance)

Maximum Plan Allowance is the amount which equals the lesser of the covered charge for a service, supply, or any dental procedure covered under the dental plan or an amount which Delta Dental establishes annually as its maximum allowable fee for the same service or supply.

For all dental procedures covered under the plan, the maximum allowable fee is established by Delta Dental of Iowa for a covered dental procedure that is dentally necessary and dentally appropriate. It is developed from various sources, such as contracts with dentists, input from our dental consultants, the simplicity or complexity of the procedure, and the billed charge for the same procedures by dentists in Iowa.

For services billed by dentists outside of Iowa, the maximum allowable fee is based on information from that state's Delta Dental Plan.

SECTION 4: YOUR PAYMENT OBLIGATIONS

PAYMENT ARRANGEMENTS

We have contracting relationships with Delta Dental dentists throughout the state. Our contracts with dentists include payment arrangements that are made possible by our broad base of customers. We use different methods to determine payment arrangements. These payment arrangements usually result in savings.

We do not have contracting relationships with Nonparticipating dentist and they do not agree to accept our payment arrangements. That means you are responsible for any difference between your nonparticipating dentist's covered charge and the Maximum Plan Allowance (Delta Allowance). It is most often to your financial advantage to receive services from Delta Dental dentists.

OUR PAYMENT POLICY

Our policy is to send our payment for treatment after it is completed - not before. For example, we will send our payment for:

- a crown when it is seated.
- a root canal when it is filled.

UNDERSTANDING AMOUNTS YOU PAY TO SHARE COSTS

■ COINSURANCE

Coinsurance is the amount, calculated using a fixed percentage, you pay each time you receive certain covered services. These amounts are shown on the SUMMARY OF PAYMENT chart at the beginning of this certificate.

Coinsurance payments begin once you meet any applicable deductible amounts. Coinsurance is calculated off the Maximum Plan Allowance (Delta Allowance). In general, the percentage of coinsurance you pay depends on the benefit category of the service you receive.

SECTION 4: YOUR PAYMENT OBLIGATIONS

■ BENEFIT PERIOD MAXIMUM

The benefit period maximum is the maximum benefit each member is eligible to receive for certain covered services in a benefit period. The benefit period maximum benefit is reached from claims settled under this certificate in a benefit period. This amount is shown on the SUMMARY OF PAYMENT chart at the beginning of this certificate.

■ LIFETIME MAXIMUM

In a member's lifetime, total benefits are limited by dollar amount for Sealant applications in BENEFIT CATEGORY: CAVITY REPAIR AND TOOTH EXTRACTIONS and BENEFIT CATEGORY: STRAIGHTER TEETH. These amounts are shown on the SUMMARY OF BENEFITS and PAYMENT chart at the beginning of this certificate.

SECTION 5: FILING CLAIMS

Once you receive dental services, we need to receive a claim to determine the amount of your benefits. The claim lets us know the services you received, when you received them, and from which dentist. You will need to file a claim only when you use *a nonparticipating dentist who does not agree to file a claim for you -Delta Dental dentists file for you.*

THE CLAIM FILING PROCESS

■ WHEN TO FILE YOUR CLAIM

After you receive services, you should file a claim only if your dentist has not filed one for you. Delta Dental may disallow payment of a claim submitted more than 365 days after the date services were rendered.

You should file a claim only after the procedure is completely finished. Do not file for payment before a procedure is completed.

If you need a claim form or have any questions after reading this section, please call us or visit our website www.deltadentalia.com. For your convenience, we have listed our toll-free number on the back cover of this certificate. If you must file your own claim, send it to the following address:

*Delta Dental of Iowa
P.O. Box 919
Ankeny, IA 50021-0919*

SECTION 5: FILING CLAIMS

FILING WHEN YOU HAVE OTHER COVERAGE

■ COORDINATION OF BENEFITS

You may have other insurance or coverage that provides the same or similar benefit(s) as this certificate. If so, we will work with your other insurance company or carrier. The benefits payable under this program when combined with the benefits paid under your other coverage will not be more than 100 percent of either our payment arrangement amount or the other carrier's payment arrangement amount.

What You Should Do.

When you receive services, you must let us know that you have other coverage. Other coverage includes: group insurance, other group benefit plans (such as HMOs, PPOs, and self-insured programs), Medicare or other governmental benefits, and the medical benefits coverage in your automobile insurance (whether issued on a fault or no-fault basis). To help us coordinate your benefits, you must:

- inform your dentist by giving him or her information about your other coverage at the time you receive services. Your dentist will pass the information on to us when the claim is filed.
- indicate that you have other coverage when you fill out a claim form by completing the appropriate boxes on the form. You will receive a letter from us if we need any additional information.

You must cooperate with us and provide requested information about your other coverage. If you do not give us necessary information, your claims will be denied.

What We Will Do.

There are certain rules we follow to help us determine which certificate pays first when you have other insurance or coverage that provides the same or similar benefits as this certificate. Here are some of the rules:

The coverage without coordination of benefits pays first when both coverage's are through a group sponsor such as an employer, but one coverage has coordination of benefits and one does not.

SECTION 5: FILING CLAIMS

- *The dental benefits of your auto coverage* will pay before this coverage if the auto coverage does not have a coordination of benefits provision.
- The coverage which you have as an *employee* or *plan member* pays before the coverage which you have as a spouse or dependent child.
- The coverage *you* have as *the result of your active employment* pays before coverage you hold as a retiree or under which you are not actively employed.
- The coverage with the *earliest continuous effective date* pays first when none of the above rules apply.

If none of the guidelines just mentioned apply to your situation, we will use the Coordination of Benefits (COB) guidelines adopted by the Iowa Insurance Division to determine our payment to you.

What You Should Know About Dependent Children.

To coordinate benefits for a dependent child the following rules apply. For a child who is:

- *covered by both parents* who are not separated or divorced or if they are, neither parent has primary physical custody, the coverage of the parent whose birthday occurs first in a calendar year pays first. If another carrier does not use this rule, then the other plan will determine which coverage pays first.
- *covered by separated or divorced parents* and a court decree says which parent has financial or dental insurance responsibility, that parent's coverage pays first.
- *covered by separated or divorced parents* and a court decree does not stipulate which parent has financial or dental insurance responsibility, then the coverage of the parent with custody pays first. The payment order for this dependent child is as follows: custodial parent, spouse of custodial parent, other parent, and spouse of other parent.

If none of these rules apply, the parent's coverage with the earliest continuous effective date pays first.

SECTION 5: FILING CLAIMS

APPEALING A DENIED CLAIM

Your Initial Request for a Review

If Delta Dental of Iowa does not pay all or part of your claim and you think the service should be covered, you or your representative can ask for a full and fair review of that claim. To file for a review, submit a request within 180 days of receiving the notice from Delta Dental of Iowa, including the reason why you disagree with our claim decision, documents, records and any other information related to the claim. Include the subscriber's name, patient's name and subscriber's identification number on all documents.

ADDITIONAL INFORMATION

You may send us additional information in writing up to 31 days after you have sent in the original request. After that time, we will make the final decision on the claim based on the information we have in your file.

DELTA DENTAL'S REPLY

Within 30 days of receiving your request, Delta Dental of Iowa will send you their written decision and indicate any action they have taken. However, when special circumstances arise, Delta Dental of Iowa may require 60 days. Delta Dental of Iowa will notify you in the event they require additional days.

REVIEWING RECORDS

Upon your request, Delta Dental of Iowa will provide you free of charge, access to and copies of all documents, records and other information relevant to your claim for benefits. You can review records that deal with your request from 8:00 a.m. to 4:30 p.m., Central Standard Time, Monday through Friday, at Delta Dental of Iowa's Ankeny, Iowa location. Since so many records are electronically filed, please call Delta Dental of Iowa in advance so they can have copies ready for you.

Send your request to:

*Delta Dental of Iowa
P.O. Box 919
Ankeny, Iowa 50021-0919
or call 1-800-544-0718*

SECTION 6: YOUR CERTIFICATE

Our responsibilities to you, as well as the conditions of your coverage with us, are defined in the documents that make up your contract. Your contract includes any *application* you submitted to us or to your employer or group sponsor, any *agreement* or *group policy* (including subsequent amendments) we have with your employer or group sponsor, any application completed by your employer or group sponsor, and this *benefits certificate*. All of the statements made by your employer or group sponsor or you in any of these materials will be treated by us as representations, not warranties. We will not use the statements to deny any claim unless we've furnished you with a copy of the statement.

COVERAGE ELIGIBILITY

■ ELIGIBLE MEMBERS

An eligible member is an employee who has met the employer's eligibility requirements, a spouse, or eligible dependent child(ren).

Spouse means your husband or wife as the result of a marriage that is legally recognized in Iowa, your common law partner, same or opposite sex domestic partner. An eligible dependent child can be your natural child, a child placed with you for adoption or a legally adopted child, a child for whom you have legal guardianship, a stepchild, or a foster child. Dependent children must meet the following requirements:

- The child is not married and either under 26 years of age or a full-time student. A full-time student is a dependent claiming status as a full-time student. The dependent must be enrolled in an accredited institution of higher learning, such as a college, university, nursing school, or trade school, and carry 12 or more hours per semester. Full-time student status continues during regularly scheduled school vacation periods; and during absence from class in which enrolled for up to four months due to a physical or mental disability. The disability must be substantiated by a written statement from a physician.

SECTION 6: YOUR CERTIFICATE

An eligible dependent child can be your natural child, a child placed with you for adoption or a legally adopted child, a child for whom you have legal guardianship, a stepchild, or a foster child. Dependent children must meet all of the following requirements:

- The child is totally and permanently disabled, either physically or mentally. If the dependent child is permanently disabled, the disability must have existed before the child was age 26, and the dependent must have had continuous creditable coverage without a break of 63 days or more since on or before that birthday.
- A dependent child who has been placed in your home for the purpose of adoption or who you have adopted shall be eligible for coverage as of the date of placement for adoption or as of the date of actual adoption, whichever occurs first. Applications for coverage for dental must be signed within 30 days of the "event" to add the new child to the existing family contract or allow a single contract to be changed to a family contract.

Legal documentation must accompany the application to add the new child indicating:

- employee name and social security number
- date of birth of the child
- date awarded physical custody

If custody is lost, it is the employee's responsibility to immediately notify their Personnel Assistant.

■ ELIGIBILITY REQUIREMENTS

Employees who are permanent or probationary and who work 20 or more hours per week are eligible to apply within 30 calendar days of the date of hire. ***Please note:*** This is the only time you may enroll.

■ PROMISE PROGRAM

PROMISE program employees, as established by Executive Order Number 27, may enroll in single or family coverage within thirty (30) calendar days of expiration of their Medicaid benefits.

SECTION 6: YOUR CERTIFICATE

■ TYPES OF COVERAGE

There are different categories of coverage you may hold under this certificate.

- With *single coverage*, the subscriber is the only one covered.
- With *family coverage*, the subscriber, his or her spouse, your common law partner, same or opposite sex domestic partner and each of his or her eligible, dependent children have coverage. Each covered family member must be listed on the subscriber's application for coverage or added later as a new member.

You may change from family to single coverage at any time during the year. The effective date will be the first of the month following your signature on an application. However, you will only be able to switch back to family coverage at the time of an event as described later in this section under *Coverage Changes*.

Qualified Medical Child Support Order (QMCSO). If you have a dependent child and your employer receives a Medical Child Support Order recognizing the child's right to enroll in this benefit plan, your employer will promptly notify both you and the dependent that the order has been received. Your employer also will inform you and the dependent of the employer's procedures for determining whether the order is a Qualified Medical Child Support Order.

To be a Qualified Medical Child Support Order, the Medical Child Support Order must clearly specify:

- your name and last known mailing address, if any;
- the name and mailing address of the dependent specified in the court order;
- a reasonable description of the type of coverage to be provided to the dependent or the manner in which the type of coverage will be determined;
- the period to which the order applies; and
- the name of each plan to which the order applies.

Also, a Qualified Medical Child Support Order cannot require that a benefit plan provide any type or form of benefit or option not otherwise provided under the plan, except as necessary to meet the requirements of Iowa Code Chapter 252E (1995) or Social Security Act Section 1908 with respect to group plans.

SECTION 6: YOUR CERTIFICATE

Within a reasonable time after receiving the order, your employer will decide whether the court order is a Qualified Medical Child Support Order and will notify you and the dependent of that determination.

Once your employer decides that a court order is a Qualified Medical Child Support Order, the order is binding on both the employer and us, meaning that the dependent is eligible to enroll under the applicable terms and conditions of the plan as well as our standard enrollment guidelines. Your employer must forward a copy of the order to us and ask that we enroll the dependent in the plan.

Within 60 days of our receipt of either the order or the application, whichever comes first, we will decide whether the dependent is eligible for enrollment and will notify your employer of the dependent's eligibility status. If your employer offers more than one plan, your employer will enroll the dependent in the same plan in which you are enrolled or a selected plan that is accessible to the dependent.

The dependent's eligibility for and enrollment in the plan will be governed by all applicable terms and conditions, including, but not limited to, eligibility standards and enrollment procedures. If eligible, the dependent will receive the same coverage that you do and will be allowed to enroll immediately regardless of normal enrollment procedures. Your employer will withhold your share, if any, of the dependent's health care premiums from your compensation and forward this amount to us.

Within 30 days of receiving the order, your employer must tell both you and the dependent that:

- the dependent has been enrolled in a benefit plan; or
- the dependent is ineligible for enrollment and why; or
- the order has been forwarded to us without a determination of the dependent's eligibility.

SECTION 6: YOUR CERTIFICATE

If the dependent enrolls in a benefit plan, your employer will provide all the following information to you and the dependent.

- The name of the insurer providing the benefit plan.
- The dependent's effective date of coverage.
- The benefit plan or account number.
- The type of benefit plan under which the dependent has been enrolled, including whether dental, vision, office visits, and prescription drugs are covered services.
- A brief description of the applicable deductibles, coinsurance, waiting periods for preexisting conditions, and other significant terms or conditions materially affecting the coverage.

The dependent may designate another person, such as a custodial parent or legal guardian, to receive copies of explanations of benefits, checks, and other materials.

If your employer decides that the order is *not a* Qualified Medical Child Support Order, each dependent specified in the order as entitled to enroll in the benefit plan may submit a written appeal to your employer. Within 30 days of receiving the appeal, your employer will respond in writing.

Your employer may not revoke enrollment or eliminate coverage for a dependent unless the employer has received satisfactory written evidence of any of the following conditions:

- The court or administrative order requiring coverage in a benefit plan is no longer in effect.
 - The dependent's eligibility for or enrollment in a comparable benefit plan that takes effect on or before the date the dependent's enrollment in this plan terminates.
 - The employer's elimination of dependent coverage for all employees.
- Your employer is not required to maintain coverage for the dependent if:
- You are no longer paying premiums because your employer no longer owes you compensation; or
 - You have terminated employment with the employer and have not elected to continue coverage.

SECTION 6: YOUR CERTIFICATE

■ **FAMILY AND MEDICAL LEAVE ACT** This Act requires a public employer to allow an employee with 12 months or more of service and who has worked for 1250 hours over the previous 12 months a total of 12 weeks of leave per fiscal year for the birth of a child, placement of a child with the Employee for adoption or foster care, care for the spouse, child or parent of the Employee if the individual has a serious health condition or because of a serious health condition, the employee is unable to perform any one of the essential functions of the employee's regular position.

Any employee taking a leave under the act shall be entitled to continue the employee's benefits during the duration of the leave. The employer must continue the benefits at the level and under the conditions of coverage that would have been provided if the Employee had remained employed.

Please note: The employee is still responsible for paying their share of the premium if applicable. If the employee for any reason fails to return from the leave, the employer may recover from the employee that premium or portion of the premium that the employer paid, provided the employee fails to return to work for any reason other than the reoccurrence of the serious health condition or circumstances beyond the control of the employee.

Leave taken under the Act does not constitute a "qualifying event" so as to trigger COBRA rights. However, a qualifying event triggering COBRA coverage may occur when it becomes known that the Employee is not returning to work. Therefore, if an employee does not return at the end of 12 weeks Family and Medical Leave and terminates employment with employer, the COBRA qualifying event occurs at that time.

If you have any questions regarding your eligibility or obligations under the Family Medical Leave Act, contact your personnel assistant.

SECTION 6: YOUR CERTIFICATE

■ WHEN COVERAGE BEGINS

If you are a newly hired employee, your coverage is effective the first of the month following 30 days of active employment. **Please note:** The month of February is considered a 30-day period.

Please note: Before you receive benefits under this certificate, you have agreed in your application for coverage (or in documents kept by us or your employer or group sponsor) to release any necessary information requested about you so we can process claims for benefits. You must allow any provider, facility or their employee, to give us information about a treatment or condition. If we do not receive the information requested, or if you withhold information in your application, your benefits may be denied.

If you fraudulently use your certificate or misrepresent or conceal material facts in your application, then we may terminate this program.

■ WHEN COVERAGE ENDS

Your eligibility for coverage will terminate at the end of the month for any of these reasons:

- You become unemployed. Termination of your coverage for this reason only applies if you receive your coverage through your employer.
- You become ineligible for coverage under this certificate. (See *Coverage Changes* in this section.)
- Your employer or group sponsor decides to discontinue coverage or replaces this coverage.
- We decide to terminate coverage of all similar certificates by giving written notice to your employer or group sponsor at least six months prior to termination.

SECTION 6: YOUR CERTIFICATE

Your coverage will end if either of the following occurs:

- You use this coverage fraudulently or you fraudulently misrepresent or conceal material facts in your application. If this happens, we will recover any claim payments we made, minus any premiums paid.
- You or your employer or group sponsor fails to make payments to us when due.

Authority to Terminate, Amend, or Modify. Your employer or group sponsor has the authority to terminate, amend or modify the coverage described in this certificate at any time. Any amendment or modification will be in writing and will be as binding as this certificate. If your contract is terminated, you may not receive benefits.

■ CONTINUED COVERAGE

There are some federal and state laws that may affect your coverage with us. They apply to continuing your coverage when you are no longer eligible for group coverage.

Coverage Continuation Under Federal Law-COBRA. COBRA entitles you and your eligible dependents to a continuation of coverage under this program if coverage is lost due to any of the following qualifying events:

- Death of the employee covered under this program.
- Termination of employment for reasons other than gross misconduct, or if your work hours are reduced to the point that you are no longer eligible for coverage.
- Divorce or legal separation.
- The employee covered under this program becomes eligible for Medicare.
- Dependent children are no longer considered dependent by our eligibility rules.

Please note: You or your eligible dependents are responsible for notifying your employer or group sponsor of a dissolution of marriage, legal separation or a child losing dependent status.

SECTION 6: YOUR CERTIFICATE

If you wish to continue your coverage, you must complete an election form and submit it to your employer within 60 days of the later of the date:

- You are no longer covered; or
- You are notified of the right to elect COBRA continuation coverage.

You will be responsible for paying any premiums for the continuation of this certificate. Depending on how you qualify, you may continue your coverage for up to 18, 29 or 36 months.

If during the period of COBRA coverage, a child is born to you or placed with you for adoption, the child can be covered under COBRA coverage and can have election rights of his or her own.

If you or any other family member who has elected COBRA coverage is determined to be disabled under the Social Security Act during the first 60 days of continuation coverage, your COBRA coverage may continue for up to 29 months. The 29-month period will apply to you and your spouse and/or eligible dependent child(ren) who elected COBRA coverage. You must provide notice of the disability determination to your employer within 60 days after the determination.

If you lose your coverage, contact your employer or group sponsor. They should help you with any necessary paperwork and let you know the cost of continuing your coverage.

Length of Coverage under COBRA.

Continuation coverage ends at the earliest of one of these events: The last day of the 18, 29 or 36 month maximum coverage period, whichever is applicable.

SECTION 6: YOUR CERTIFICATE

- The first day (including grace periods, if applicable) on which timely payment is not made.
- The date on which the employer ceases to maintain any group plan including successor plans).
- The first day on which a beneficiary is actually covered by any group plan. However, if the new group plan contains an exclusion or limitation relating to any preexisting condition of the beneficiary, then coverage will end on the earlier of the satisfaction of the waiting period for preexisting conditions contained in the new group plan or upon the occurrence of any one of the other events stated in this section. If the new group plan contains a preexisting waiting period exclusion, the preexisting condition waiting period will be reduced by the qualified beneficiary's period of "prior creditable coverage" as of the enrollment date in the new group health plan.
The date the qualified beneficiary is entitled to Medicare benefits.

Continuation of Group Coverage

Iowa Code Sections 509A.7 and 509A.13 may apply to you if you are an employee of the State, a school district in Iowa, or any other entity supported by public funds. This law entitles you to continue participation in this plan when you retire. You are responsible for paying any premiums.

SECTION 6: YOUR CERTIFICATE

COVERAGE CHANGES

■ EVENTS CHANGING COVERAGE

Certain events may require you to change who is covered by this certificate. A change may occur if application is made within thirty (30) calendar days of any of the following events (except birth or adoption of a child which is 60 days). Only dependents directly affected by the event may be added to coverage.

■ Events allowing you to add dependents:

Adoption or Placement for Adoption.

Addition of a Stepchild.

Appointment as a Legal Guardian of a child

Care of a Foster Child (when placed in your home by an approved agency).

Death of a Spouse or Dependent.

Divorce, Annulment, or Legal Separation. or Dissolution of Marriage.

Dependent resumes full time student status.

Marriage.

Spouse loses coverage through another employer due to

Involuntary loss of employment (lay-off, discharge, business closing). Proof of loss shall be the “Involuntary Loss of Coverage Statement” signed and dated by the previous employer.)

Birth of a biological child. A dental enrollment form is always required when adding a newborn. If moving from single to family, the effective date of the family contract will be the first day of the month in which the child is born. Family premiums will begin with this effective date. If a contract holder does not submit the application within 60 days of the birth, there is no further opportunity to add the newborn.

SECTION 6: YOUR CERTIFICATE

■ **Events that may require you to remove dependents:**

Active Duty in the Military

Death of a Spouse or Dependent.

Dependent Child no longer eligible (age 26 and not a full time student or permanently disabled; no longer an Iowa resident or dependent marries).

Divorce, annulment, legal separation, or dissolution of marriage.

Employee or spouse reaches age 65.

■ **AUTHORIZED CERTIFICATE CHANGES** No agent, employee or representative of ours is authorized to vary, add to, change, modify, waive or alter any of the provisions of this certificate. This certificate cannot be changed except by:

- *written amendment* signed by an authorized officer and accepted by you, or your employer or group sponsor.

COVERAGE TERMINATION

■ **EFFECTS OF TERMINATION** If your certificate is terminated for fraud, misrepresentation, or the concealment of material facts:

- we *will not pay* for any services or supplies provided after the date your coverage is terminated.
- we *will retain legal rights*. This includes the right to initiate a civil action based on fraud, concealment, or misrepresentation.
- we *may*, at our option, *declare the certificate void*.

If your certificate is terminated for reasons other than fraud, concealment or misrepresentation of material facts, we will stop benefits the day your certificate is terminated.

SECTION 6: YOUR CERTIFICATE

OUR RIGHT TO RECOVER PAYMENTS

■ PAYMENT IN ERROR

If for any reason we make payment under this certificate in error, we may recover the amount we paid.

■ SUBROGATION

You will once you receive benefits under this certificate arising from an illness or injury, we will assume any legal right you have to collect compensation, damages, or any other payment related to the illness or injury, including benefits from any of the following:

- The responsible person's insurer.
- Uninsured motorist coverage.
- Underinsured motorist coverage.
- Other insurance coverage.

You and your family agree to all of the following:

- You will let us know about any potential claims or rights of recovery related to the illness or injury;
- You will furnish any information and assistance that we determine we will need to enforce our rights under this program;
- You do nothing to prejudice our rights and interests;
- You will not compromise, settle, surrender, or release any claim or right of recovery described above, without getting our written permission,
- You must reimburse us to the extent of benefit payments made under this certificate if payment is received from the other party or parties.

You and your covered family member(s) must notify us if you have the potential right to receive payment from someone else. You must cooperate with us to ensure that our rights to subrogation are protected.

SECTION 6: YOUR CERTIFICATE

OTHER INFORMATION

■ NOTICE

If a specific address has not been provided elsewhere in this certificate, you may send any notice to our home office:

*Delta Dental of Iowa
P. O. Box 919
Ankeny, IA 50021-0919*

Any notice from us to you is acceptable when sent to your address as it appears on our records or the address of the group through which you are enrolled.

■ NONASSIGNMENT

Benefits for covered services in this certificate are for you personal benefit and cannot be transferred or assigned to anyone else without our consent. Any attempt to assign this coverage or rights to payment without our consent will be void.

■ Acquisition by States of Rights of Third Parties

If payment has been made by Medicaid and we have a legal obligation to provide benefits for those services, then we will make payment of those benefits in accordance with any state law under which a state acquires the right to such payments.

■ GOVERNING LAW

To the extent not superseded by the laws of the United States, this certificate will be construed in accordance with and governed by the laws of the state of Iowa. Any action brought because of a claim under this program will be litigated in the state or federal courts located in the state of Iowa and in no other.

■ LEGAL ACTION

No legal or equitable action may be brought against us because of a claim under this certificate, or because of the alleged breach of this certificate, more than two years after the end of the calendar year in which the services or supplies were provided.

SECTION 6: YOUR CERTIFICATE

■ **INFORMATION IF YOU OR A MEMBER OF YOUR FAMILY IS ENROLLED IN MEDICAID Assignment of Rights.** This plan will provide payment of benefits for covered services to you, your beneficiary, or to any other person who has been legally assigned the right to receive such benefits under requirements established pursuant to Title XIX of the Social Security Act (Medicaid).

■ **ENROLLMENT WITHOUT REGARD TO MEDICAID.**

Your receipt or eligibility for medical assistance under Title XIX of the Social Security Act (Medicaid) will not affect your enrollment as a participant or beneficiary of this plan, nor will it affect our determination of any benefits paid to you.

SECTION 7: GLOSSARY

Benefit Category refers to a grouping of benefits related to a specific type of dental service. For example, **BENEFIT CATEGORY: CHECK-UPS AND TEETH CLEANING** includes the following diagnostic and preventive services:

1. Dental Cleaning.
2. Oral Evaluations.
3. Topical Fluoride Applications.
4. X-rays (Bitewing, Full Mouth, Occlusal, Extraoral, Periapical).

Benefit Period is the same as a calendar year. It begins on the day your coverage goes into effect and starts over each January 1. This is true for as long as you have coverage.

Benefit Period Maximum is the maximum benefit each member is eligible to receive for certain covered services during a benefit period.

Benefits means those dentally necessary and dentally appropriate procedures that qualify for payment under this program.

Cast means a laboratory procedure in which a restoration is pre-constructed from a material such as gold or porcelain.

Cast Restorations restore teeth to acceptable form and function when the tooth cannot be restored with a routine filling.

Claims Settled is the amount that is discharged when your claim is processed.

Coinurance is the amount, calculated using a fixed percentage, you pay each time you receive certain covered services.

Contract includes any application you submitted to us or your employer or group sponsor for coverage, any agreement or group policy we have with your employer or group sponsor, any application completed by your employer or group sponsor, this benefits certificate, and any riders or amendments.

Contractholder refers to you, the subscriber who signed for this certificate.

SECTION 7: GLOSSARY

Contract Limitations are amounts that are your liability based on your contractual obligations with us. Examples of contract limitations include services that are not covered; services that are not dentally necessary; and services that are subject to dental limitations.

Coordination of Benefits (COB) applies when you are covered by more than one group contract or commercial insurance policy providing benefits for like services. COB is a method of limiting insurance coverage to no more than 100 percent of either our payment arrangement amount or the other carrier's payment arrangement amount.

Covered Services are those dentally necessary and dentally appropriate procedures listed in the Benefits section of this certificate.

Creditable Coverage means any of the following types of coverage that you, the member, had without a break in coverage of 63 days or more:

- A group health plan.
- Health insurance coverage.
- Part A or B of Title XVIII of the Social Security Act (Medicare).
- Title XIX of the Social Security Act (Medicaid).
- Chapter 55 of Title 10, United States Code.
- A medical care program of the Indian Health Service or of a tribal organization.
- A State health benefits risk pool.
- A health plan offered under Chapter 89 of Title 5, United States Code.
- A public health plan (as defined in regulations).
- A health benefit plan under Section 5(e) of the Peace Corps Act.

Delta Allowance has been replaced with Maximum Plan Allowance. See Maximum Plan Allowance for description.

Dentally Appropriate means:

- The treatment is the most appropriate procedure for your individual circumstances.
- The treatment is consistent with and meets professionally recognized standards of dental care and complies with criteria adopted by us.

SECTION 7: GLOSSARY

- The treatment is not more costly than alternative services that would be equally effective for treatment or maintenance of your teeth and their supporting structures.

Dentally Necessary means:

- The diagnosis is proper.
- The treatment is necessary to preserve or restore the form and function of the tooth or teeth and the health of the gums, bone, and other tissues supporting the teeth.

Dentist means an individual who is licensed to practice dentistry under the laws of Iowa or who is licensed in the state where you receive services.

Dependent Child means your natural child, a legally adopted child, a child placed with you for adoption, a child for whom you have legal guardianship, a stepchild, or foster child. To be eligible for coverage, the child must be unmarried and either under 26 years of age, a full-time student, totally and permanently disabled, either physically or mentally. If the dependent child is permanently disabled, the disability must have existed before the child was age 26 or while the child was a full-time student, and the dependent must have had continuous creditable coverage without a break of 63 days or more since on or before that birthday. A dependent child who has been placed in your home for the purpose of adoption or whom you have adopted shall be eligible for coverage as of the date of placement for adoption or the date of actual adoption, whichever occurs first.

Effective Date is the date upon which this coverage goes into effect.

Emergency is a condition which requires immediate dental care for the relief of pain or infection of dental origin.

Endodontics is the treatment or removal of injured or infected tissue within the crown and root of the tooth.

Family Coverage means coverage for the plan member and his or her eligible family members.

SECTION 7: GLOSSARY

Family Member means to any member of a plan member's family (including the plan member) covered under this coverage.

Full-time Student claiming status as a full-time student.

The dependent must be enrolled in an accredited is a dependent institution of higher learning, such as a college, university, nursing school, or trade school. (Twelve or more hours per semester is generally considered full-time status.) Full-time student status continues during:

- regularly scheduled school vacation periods; and
- absence from class, in which enrolled, for up to four months due to a physical or mental disability. The disability must be substantiated by a written statement from a practitioner.

Group is made up of those plan members who share a common relationship such as employment or membership.

Identification Card has been replaced by an Information Card. See below for description of your information card.

Information Card is a card issued to you by us. You have the option to write in your name and identification number. You should carry your information card with you at all times and present it to your provider at the time you receive care.

Implants are surgically placed devices which will eventually support a fixed or removable prosthesis.

Lifetime Maximum is the total benefits allowed for benefit category: STRAIGHTER TEETH during each member's lifetime under this coverage and any other Delta Dental of Iowa coverage.

Limitation is a certain condition placed on a benefit that limits coverage.

Maximum Plan Allowance (Delta Allowance)

Maximum Plan Allowance is the amount which equals the lesser of the covered charge for a service, supply, or any dental procedure covered under the dental plan or an amount which Delta Dental establishes annually as its maximum allowable fee for the same service or supply.

SECTION 7: GLOSSARY

Medical Child Support Order. A Medical Child Support Order means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that:

- provides for child support with respect to a plan member's child or a child of the plan member's spouse or provides for coverage to such a child, is made pursuant to a State domestic relations law, and relates to benefits under the benefit plan of the plan member; or
- enforces a law relating to medical child support described in Code of Iowa Chapter 252E (1995) or Section 1908 of the Social Security Act with respect to a group plan.

Member

- for single coverage means the plan member
- for family coverage means the plan member and his or her spouse and eligible dependent children

Nonparticipating Dentist is a dentist who does not hold a valid participating agreement with us at the time you receive covered services.

Occlusal Adjustment (Complete) is a complex procedure which requires several appointments and is intended to revise or alter the functional relationships between your upper and lower teeth. Mounting study casts on an articulating instrument is necessary for pre-treatment analysis.

Occlusal Adjustment (Limited) is a procedure to reshape the biting surfaces of one or more teeth.

Orthodontics is treatment to straighten the teeth.

Our means Delta Dental of Iowa.

Participating Dentist is a dentist who holds a valid participating agreement with us at the time you receive services.

Periodontial Services means treatment for gum and bone diseases.

Practitioner means any individual recognized by us, licensed and/or accredited to provide covered services.

SECTION 7: GLOSSARY

Prosthetics is the replacement of missing permanent teeth by fixed or removable devices such as bridges and dentures.

Provider means a practitioner or facility.

Qualified Medical Child Support Order (QMCSO). A Qualified Medical Child Support Order is a Medical Child Support Order that creates or recognizes a specified in the person's right to enroll in the benefit plan for which the plan member or his/her dependents are eligible. A QMCSO includes the following information:

- The name and last known mailing address (if any) of the plan member and the name and mailing address of each person specified in the order as entitled to enroll in the group plan;
- A reasonable description of the type of coverage to be provided or the manner in which the type of coverage is to be determined;
- The period to which the order applies; and
- Each plan to which the order applies. To be a Qualified Medical Child Support Order, the order cannot require a benefit plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of Code of Iowa Chapter 252E (1995) or Section 1908 of the Social Security Act with respect to a group plan.

Root is the anatomic portion of the tooth that is covered by cementum and is normally contained in the socket (alveolus).

Root Canal is the portion of the pulp cavity inside the root of a tooth which houses nerves and blood vessels.

Root Planing is removal of infected cementum from the root surface of a tooth.

Root Scaling is removal of disease-causing substances from the root surface of a tooth.

Single Coverage means coverage for the plan member only.

Spouse refers to your husband or wife as the result of a marriage that is legally recognized in Iowa, your common law partner, same or opposite sex domestic partner.

SECTION 7: GLOSSARY

Subrogation means our rights when you or your family members receive benefits of this certificate required as the result of illness or injury and you have a lawful claim against another party or parties for compensation, damages or other payment.

Termination Date is the date your coverage ends under this certificate. See *When Coverage Ends* in: YOUR CERTIFICATE section.

Treatment Plan describes the treatment your dentist has recommended for you and helps us determine if the procedure is a benefit of your coverage as well as dentally necessary and dentally appropriate.

Us means Delta Dental of Iowa.

We means Delta Dental of Iowa.

X-rays (Bitewing) show the visible part of the teeth of both the upper and lower jaws and are used to detect cavities and periodontal disease.

X-rays (Extraoral) show the jaw and are used for orthodontic analysis or to detect fractures, jaw disorders, or other abnormalities. These x-rays are taken from outside the mouth.

X-rays (Full Mouth) include a series of periapical and bitewing x-rays showing the teeth and underlying structures of the entire mouth.

X-rays (Occlusal) show the underlying structures of the teeth and are used to detect cysts and pathologies. These x-rays are taken from inside the mouth.

X-rays (Periapical) show the tooth and underlying structures for one or more teeth.

You and Your means you and your family members who are eligible for coverage under this coverage.

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