

**DELTA DENTAL PPO PLUS PREMIER -
COMPREHENSIVE ENHANCED**
with Orthodontic Coverage

Dental Benefit Plan Summary

Douglas County
Group Number 923797

Effective January 1, 2017

ADMINISTRATION

The following information is provided as required by the Employee Retirement Income Security Act (ERISA) of 1974.

PLAN SPONSOR, FIDUCIARY AND ADMINISTRATOR:

Douglas County
1819 Farnam Street, Suite 505
Omaha, NE 68183
Telephone: (402) 444-6099

AGENT FOR SERVICE OF LEGAL PROCESS:

Douglas County
1819 Farnam Street, Suite 505
Omaha, NE 68183
Telephone: (402) 444-6099

FUNDING: This Plan is self-funded. Your contribution towards the cost of the coverage under the Plan will be determined by the Employer each year and communicated to you prior to the effective date of any changes in the cost of the coverage.

EMPLOYER IDENTIFICATION NUMBER: 47-6006455

DELTA GROUP NUMBER: 923797

PLAN BENEFITS ADMINISTERED BY:

DELTA DENTAL OF NEBRASKA
National Dedicated Service Center
Atrium Executive Square
11235 Davenport Street, Suite 113
Omaha, NE 68154
(402) 397-4878 or (800) 736-0710

DENTAL BENEFIT PLAN SUMMARY

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

Douglas County
(GROUP)

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

IMPORTANT

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

DELTA DENTAL OF NEBRASKA

Administrative Offices

Atrium Executive Square
11235 Davenport Street, Suite 113
Omaha, NE 68154
(402) 397-4878 or (800) 736-0710

TABLE OF CONTENTS

SUMMARY OF DENTAL BENEFITS.....	1
Copayment Percentage of Coverage	1
Maximums and Deductibles	1
Coverage Year	1
DESCRIPTION OF COVERED PROCEDURES.....	2
Pretreatment Estimate	2
Benefits	2
Exclusions	11
Limitations	12
Post Payment Review	12
Optional Treatment Plans.....	13
ELIGIBILITY	13
Employee.....	13
Dependents	13
Effective Dates of Coverage.....	14
Open Enrollment.....	14
Family Status Change	14
Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).....	15
Termination of Coverage	16
Continuation of Coverage (COBRA)	16
PLAN PAYMENTS	18
Participating Dentist Network	18
Covered Fees	18
Claim Payments	19
Coordination of Benefits (COB).....	20
Claim and Appeal Procedures.....	24
GENERAL INFORMATION.....	25
Health Plan Issuer Involvement.....	25
Legal Action.....	25
Privacy Notice.....	26
How to Find a Participating Dentist	26
Using Your Dental Program.....	26
Cancellation and Renewal.....	26
EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA).....	27
Plan Administration.....	27
Funding Policy and Payment.....	27
Procedure to Request Information	27
Statement of ERISA Rights	27

SUMMARY OF DENTAL BENEFITS

After you have satisfied the deductible, if any, your dental program pays the following percentages of the treatment cost, up to a maximum fee per procedure. The maximum fee allowed by Delta Dental is different for Delta Dental PPO dentists, participating dentists and nonparticipating dentists. If you see a nonparticipating dentist, your out-of-pocket expenses may increase.

	<u>Delta Dental PPO</u>	<u>Delta Dental Premier</u>	<u>Out-of- Network</u>
Diagnostic and Preventive Services	80%	80%	80%
Basic Services	80%	80%	80%
Endodontics	80%	80%	80%
Periodontics	80%	80%	80%
Oral Surgery	80%	80%	80%
Major Restorative Services	60%	60%	60%
Prosthetic Repairs and Adjustments.....	60%	60%	60%
Prosthetics	60%	60%	60%
Orthodontics	60%	60%	60%

Benefit Maximums

The Program pays up to a maximum of \$1,250.00 for each Covered Person per Coverage Year subject to the coverage percentages identified above. Benefit Maximums may not be carried over to future coverage years.

Orthodontics is subject to a separate lifetime maximum of \$1,500.00 per Covered Person and limited to those orthodontic treatment plans commenced on or after the Eligible Dependent Child's eighth (8th) birthday. Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. The Covered Person must remain eligible under the Plan in order to receive continued benefit payments.

Deductible

There is a \$25.00 deductible per Covered Person each Coverage Year for Major Restorative, Prosthetic Repair and Adjustment, Prosthetic and Orthodontic Services.

Coverage Year

A Coverage Year is a 12-month period in which deductibles and benefit maximums apply. Your Coverage Year is January 1 through December 31.

DESCRIPTION OF COVERED PROCEDURES

Pretreatment Estimate

(Estimate of Benefits)

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

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

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

Benefits

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

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

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

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

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

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

PREVENTIVE CARE (Diagnostic & Preventive Services)

Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per calendar year period.

NOTE: Comprehensive oral evaluations will be benefited 1 time per dental office, subject to the 2 times per calendar year period limitation. Any additional comprehensive oral evaluations performed by the same dental office will be benefited as a periodic oral evaluation and will be subject to the 2 times per calendar year period limitation.

Radiographs (X-rays)

- **Bitewings** - Covered at 1 series per calendar year period.
- **Full Mouth (Complete Series) or Panoramic** - Covered 1 time per 36-month period.
- **Periapical(s)**
- **Occlusal** - Covered at 2 series per 24-month period.

Dental Cleaning

- **Prophylaxis** (Cleaning of teeth) shall be covered as follows:
 - Two (2) dental prophylaxis per calendar year period;
 - An additional two (2) periodontal maintenance per calendar year period:
Or
 - A total of four (4) periodontal maintenance per calendar year period.

Prophylaxis

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

- **Periodontal Maintenance**

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

Fluoride Treatment (Topical application of fluoride) - Covered 2 times per calendar year period for dependent children through the age of 15.

Oral Hygiene Instructions - Instructions which include tooth-brushing techniques, flossing and use of oral hygiene aids are covered 1 time per lifetime.

Space Maintainers - Covered 1 time per lifetime on eligible dependent children through the age of 15 for extracted primary posterior (back) teeth.

LIMITATION: Repair or replacement of lost/broken appliances is not a covered benefit.

BASIC SERVICES

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

Consultations - Covered as long as the provider conducting the consultation is not the treating provider.

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

Composite (white) Resin Restorations

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

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

Recement Inlay, Onlay or Permanent Crown

Inlay, Onlay, Permanent Crown or Veneer Repair

Occlusal Adjustments

Sedative Filling

Therapeutic Drug Injection

Repairs - Covered 1 per 6-month period.

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

Other Basic Services

- **Restorative cast post and core build-up, including pins and posts** - See benefit coverage description under Complex or Major Restorative Services.
- **Pre-fabricated or Stainless Steel Crown** - Covered 1 time per 5 year period for eligible dependent children through the age of 18.

- **Sealants or Preventive Resin Restorations** - Any combination of these procedures is covered 1 time per 48-months for permanent first and second molars of eligible dependent children through the age of 15.

Adjunctive General Services

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

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

EXCLUSIONS - Coverage is NOT provided for:

1. Deep sedation/general anesthesia, analgesia, analgesic agents, medicines, or drugs for non-surgical or surgical dental care.
2. Case presentation and office visits.
3. Athletic mouthguard, enamel microabrasion, and odontoplasty.
4. Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes, but is not limited to whitening agents and tooth bonding.
5. Placement or removal of base or liner used under a restoration.
6. Amalgam or composite restorations placed for preventive or cosmetic purposes.

BASIC ENDODONTIC SERVICES (NERVE OR PULP TREATMENT)

Endodontic Therapy on Primary Teeth

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

Endodontic Therapy on Permanent Teeth

- **Root Canal Therapy** - Covered 1 time per 24 months.
- **Apicoectomy** - Covered 1 time per tooth per lifetime.
- **Root Amputation on posterior (back) teeth** - Covered 1 time per tooth per lifetime.

Complex or other Endodontic Services

- **Apexification** - Covered 1 time per 24 months for dependent children through the age of 16.
- **Retrograde filling** - Covered 1 time per 24 months.
- **Hemisection, includes root removal** - Covered 1 time per tooth per lifetime.

EXCLUSIONS - Coverage is NOT provided for:

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

4. Intentional reimplantation.
5. Endodontic endosseous implant.

PERIODONTICS (GUM & BONE TREATMENT)

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

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

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

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

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

EXCLUSIONS - Coverage is NOT provided for:

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

ORAL SURGERY (TOOTH, TISSUE, OR BONE REMOVAL)

Basic Extractions

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

Complex Surgical Extractions

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

Other Complex Surgical Procedures

- Oroantral fistula closure - Covered 1 time per 24 months.
- Sinus perforation - Covered 1 time per 24 months.
- Tooth reimplantation - accidentally evulsed or displaced tooth
- Biopsy of oral tissue
- Transseptal fibrotomy
- Alveoplasty
- Vestibuloplasty
- Osteoplasty
- Excision of lesion or tumor
- Removal of nonodontogenic or odontogenic cyst or tumor
- Removal of exostosis
- Partial ostectomy
- Incision & drainage of abscess
- Frenulectomy (frenectomy or frenotomy)

LIMITATIONS

Unless stated otherwise above, all services listed above are covered 1 time per tooth per lifetime.

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

EXCLUSIONS - Coverage is NOT provided for:

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

COMPLEX OR MAJOR RESTORATIVE SERVICES

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

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

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

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

Onlays - Covered 1 time per 5 year period per tooth.

Permanent Crowns - Covered 1 time per 5 year period per tooth.

Implant Crowns - See Prosthetic Services.

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

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface - Covered 1 time per 5 year period when done in conjunction with covered services.

Veneers - Covered 1 time per 5 year period.

Canal prep & fitting of preformed dowel & post

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
3. Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding.
4. Placement or removal of base or liner used under a restoration.
5. Temporary, provisional or interim crown.
6. Occlusal procedures including occlusal guard.

PROSTHETIC SERVICES (DENTURES, PARTIALS, AND BRIDGES)

Reline, Rebase, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) - Covered when:

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

Adjustments - Covered 2 times per 12-month period:

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

Removable Prosthetic Services (Dentures and Partials) - Covered 1 time per 5 year period:

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) - Covered 1 time per 5 year period:

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

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

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

Restorative cast post and core build-up, including pins and posts - Covered 1 time per 5 year period when done in conjunction with covered fixed prosthetic services.

Tissue conditioning - Covered 2 times per 36 months.

Recent fixed partial denture - Covered 1 time per 12 months.

Fixed partial denture repair - Covered 1 time per 12 months.

EXCLUSIONS - Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
3. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
4. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
5. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
6. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
7. Services or supplies that have the primary purpose of improving the appearance of your teeth.
8. Placement or removal of base or liner used under a restoration.

9. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
10. Coverage shall be limited to the least expensive professionally acceptable treatment.

ORTHODONTICS

Treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies.

Limited Treatment

Treatments which are not full treatment cases and are usually done for minor tooth movement.

Interceptive Treatment

A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.

Comprehensive (complete) Treatment

Full treatment includes all records, appliances and visits.

Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.

Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.

Other Complex Surgical Procedures

- **Surgical exposure of impacted or unerupted tooth for orthodontic reasons**
- **Surgical repositioning of teeth**

LIMITATION: Treatment in progress (appliances placed prior to eligibility under this Plan) will be benefited on a pro-rated basis.

LIMITATION: Covered eligible dependent children from the age of 8.

EXCLUSIONS - Coverage is NOT provided for:

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service;
4. Retreatment and/or services for any treatment due to relapse;
5. Inpatient or outpatient hospital expenses; and
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments: Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. The Covered Person must have continuous eligibility under the Plan in order to receive ongoing orthodontic benefit payments.

Benefit payments are made in equal amounts: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or until the lifetime maximum benefits are exhausted (see Benefit Maximums in this Plan Summary).

Before treatment begins, the treating dentist should submit a Pre-treatment Estimate. An Estimate of Benefits form will be sent to you and your dentist indicating the estimated plan payment amount. This form serves as a claim form when treatment begins.

When treatment begins, the dentist should submit the Estimate of Benefit form with the date of placement and his/her signature. After benefit and eligibility verification by the Plan, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be issued to you and your dentist. This again will serve as the claim form to be submitted 6 months from the date of appliance placement.

Exclusions

Coverage is NOT provided for:

- a) Dental services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving Medical Assistance.
- b) Dental services or health care services not specifically covered under the Group Dental Plan Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).
- c) New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.
- d) Dental services performed for cosmetic purposes. NOTE: Dental services are subject to post-payment review of dental records. If services are found to be cosmetic, we reserve the right to collect any payment and the member is responsible for the full charge.
- e) Dental services completed prior to the date the Covered Person became eligible for coverage.
- f) Services of anesthesiologists.
- g) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.
- h) Deep sedation/general anesthesia, analgesia, analgesic agents, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.
- i) Dental services performed other than by a licensed dentist, licensed physician, his or her employees.
- j) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- k) Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
- l) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding.
- m) Orthodontic treatment services, unless specified in this Dental Benefit Plan Summary as a covered dental service benefit.
- n) Case presentations and office visits.
- o) Incomplete, interim or temporary services.
- p) Athletic mouth guards, enamel microabrasion and odontoplasty.
- q) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.

- r) Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
- s) Bacteriologic tests.
- t) Cytology sample collection.
- u) Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.
- v) Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
- w) Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).
- x) The replacement of an existing partial denture with a bridge.
- y) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- z) Provisional splinting, temporary procedures or interim stabilization.
- aa) Placement or removal of base or liner used under a restoration.
- bb) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
- cc) Occlusal procedures including occlusal guard.
- dd) Amalgam or composite restorations placed for preventive or cosmetic purposes.

Limitations

- a) **Optional Treatment Plans:** in all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Person and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.
- b) **Reconstructive Surgery:** benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, provided, however, that such services are dental reconstructive surgical services.

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

Post Payment Review

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

Optional Treatment Plans

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

ELIGIBILITY

Covered Persons under this Program are:

Employees

- a) All eligible employees who have met the eligibility requirements as established by the Group and stated within this Dental Benefit Plan Summary under Effective Date of Coverage.
- b) Employees on Family and Medical Leave as mandated by the Federal FMLA.

Dependents

A) Spouse, meaning:

1. Legally married, regardless of whether that person is of the same gender or opposite gender of the employee;
2. Legally separated;

B) Dependent children to the age of 30, including:

1. Natural-born and legally adopted children (including children placed with you for legal adoption). NOTE: A child's placement for adoption terminates upon the termination of the legal obligation of total or partial support.
2. Stepchildren who reside with you.
3. Grandchildren who are financially dependent on you and reside with you as long as you have "court approved guardianship".
4. Children who are required to be covered by reason of a Qualified Medical Child Support Order. You can obtain, without charge, a copy of procedures governing Qualified Medical Child Support Orders ("QMCSOs") from the Plan Administrator.
- 5.
6. Unmarried children or step children age 26 and up to their 30th birthday so long as the dependent doesn't have other employer sponsored benefits available to them and they reside in the State of Nebraska.
7. Children who become handicapped prior to reaching the Plan's limiting age if:
 - they are primarily dependent upon you; and
 - are incapable of self-sustaining employment because of physical handicap, mental retardation, mental illness or mental disorders

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

Effective Dates of Coverage

Eligible Employee:

You are eligible to be covered under this Program when the Program first became effective, or if you are a new employee of the Group, on the first (1st) of the month following thirty (30) days of employment. An employee is eligible to enroll in the plan if the employee is a regular employee who is scheduled to work more than 20 hours per week.

Eligible Dependents:

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

- a) On the date you first become eligible for coverage, if dependent coverage is provided or elected.
- b) On the date you first acquire eligible dependents, or add dependent coverage subject to the open enrollment requirements of the Group, if any.
- c) On the date a new dependent is acquired if you are already carrying dependent coverage.

LIMITATION: Dependents of an eligible employee who are in active military service are not eligible for coverage under the Program.

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

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

Open Enrollment

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

Family Status Change

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

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

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

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

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Continuation of Benefits: Covered employees who are absent due to service in the uniformed services and/or their covered dependents may continue coverage under USERRA for up to 24 months after the date the covered employee is first absent due to uniformed service duty. To continue coverage under USERRA, covered employees and/or their dependents should contact their Employer.

Eligibility: A covered employee is eligible for continuation under USERRA if he or she is absent from employment because of service in the uniformed services as defined in USERRA. This includes voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard or the commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

Covered employees and dependents who have coverage under the Plan immediately prior to the date of the covered employee's covered absence are eligible to elect continuation under USERRA.

Contribution Payment: If continuation of Plan coverage is elected under USERRA, the covered employee or covered dependent is responsible for payment of the applicable cost of COBRA coverage. If, however, the covered employee is absent for not longer than 31 calendar days, the cost will be the amount the covered employee would otherwise pay for coverage (at employee rates). For absences exceeding 31 calendar days, the cost may be up to 102% of the cost of coverage under the Plan. This includes the covered employee's share and any portion previously paid by the Employer.

Duration of Coverage: Elected continuation coverage under USERRA will continue until the earlier of:

- 24 months, beginning the first day of absence from employment due to service in the uniformed services;
- the day after the covered employee fails to apply for or return to employment as required by USERRA, after completion of a period of service;
- the early termination of USERRA continuation coverage due to the covered employee's court-martial or dishonorable discharge from the uniformed services; or
- the date on which this Plan is terminated so that the covered employee loses coverage.

Covered employees should contact their Employer with any questions regarding continuation coverage and notify the Employer of any changes in marital status or a change of address.

Reemployment: An individual whose coverage under the Plan was terminated by reason of service in the uniformed services and who did not continue coverage during leave must, nevertheless, be entitled to reinstatement of coverage upon reemployment.

Termination of Coverage

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

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

For extended eligibility, see Continuation of Coverage.

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

Continuation of Coverage (COBRA)

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

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

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

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

1. Choosing Continuation

If you lose coverage, your employer must notify you of the option to continue coverage within 14 days after employment ends. If coverage for your dependent ends because of divorce, legal separation, or any other change in dependent status, you or your covered dependents must notify your employer within 60 days.

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

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

2. Second qualifying event

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

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

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

3. Terminating Continuation of Coverage - COBRA

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

- a) The expiration of the specified period of time for which Continuation of Coverage - COBRA can be maintained; as mandated by applicable State or Federal law;
- b) This Program is terminated by the Group Subscriber;
- c) The Group Subscriber's or Covered Person's failure to make the payment for the Covered Person's Continuation of Coverage

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

PLAN PAYMENTS

Participating Dentist Network

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

A Delta Dental PPO network dentist is a dentist who has signed Delta Dental PPO agreement with Delta Dental of Nebraska. The dentist has agreed to accept the Delta Dental PPO Maximum Amount Payable as payment in full for covered dental care. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental PPO dentist has agreed not to bill more than the Delta Dental PPO Maximum Amount Payable. A Delta Dental PPO dentist has also agreed to file the claim directly with Delta Dental.

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

Covered Fees

Under this Program, YOU ARE FREE TO GO TO THE DENTIST OF YOUR CHOICE. You may have additional out-of-pocket costs if your dentist is not a participating Delta Dental PPO or Delta Dental Premier dentist with the plan. There may also be a difference in the payment amount if your dentist is not a participating dentist with Delta Dental. This payment difference could result in some financial liability to

you. The amount is dependent on the nonparticipating dentist's charges in relation to the Table of Allowances determined by Delta Dental.

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

Claim Payments

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

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

Delta Dental Premier Dentists:

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

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

Nonparticipating Dentists:

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

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

Coordination of Benefits (COB)

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

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** does not exceed 100% of the total **Allowable expense**.

DEFINITIONS

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

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

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

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

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

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

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

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

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

- (1) The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses.
 - (2) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.
 - (3) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
 - (4) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.
 - (5) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
- E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

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

- A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.
- B. (1) Except as provided in Paragraph (2), a **Plan** that does not contain a **coordination of benefits** provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.
 - (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.
- C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.
- D. Each **Plan** determines its order of benefits using the first of the following rules that apply:

- (1) Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.
- (2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:
 - (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**;
or
 - If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.
 - (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
 - (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
 - (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
 - (iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The **Plan** covering the **Custodial parent**;
 - The **Plan** covering the spouse of the **Custodial parent**;
 - The **Plan** covering the **non-custodial parent**; and then
 - The **Plan** covering the spouse of the **non-custodial parent**.
 - (c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
- (3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

- (4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.
- (6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

- A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a covered person is enrolled in two or more **Closed panel** plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

Claim and Appeal Procedures

Initial Claim Determinations

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

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

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

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

Appeals

First Level Grievance Appeal

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

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

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

Second Level Grievance Appeal

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

If you cannot make the panel Delta Dental, at your request, will offer you the opportunity to communicate with the grievance panel by conference call. The panel will issue a decision to you within five business days of the grievance panel.

Your appeal must include your name, your identification number, group number, claim number, and dentist's name as shown on the Explanation of Benefits. Send your appeal to the address shown on the Explanation of Benefits.

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

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

To the extent your plan is covered by ERISA, after you have exhausted all appeals, you may file a civil action under section 502(a) of ERISA.

Authorized Representative

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

GENERAL INFORMATION

Health Plan Issuer Involvement

FOR SELF-FUNDED: The benefits under the Plan are not guaranteed by Delta under the Contract. As Claims Administrator, Delta pays or denies claims on behalf of the Plan and reviews requests for review of claims as described in the Claim and Appeals Procedures section.

Legal Action

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Privacy Notice

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

How to Find a Participating Dentist

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

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

Using Your Dental Program

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

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

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

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

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

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

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

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

- * YOUR DELTA DENTAL GROUP NUMBER
- * YOUR EMPLOYER (GROUP NAME)
- * YOUR IDENTIFICATION NUMBER (your dependents must use **YOUR** identification number)
- * YOUR BIRTHDAY AND THE BIRTH DATES OF YOUR SPOUSE AND DEPENDENT CHILDREN

Cancellation and Renewal

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

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

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Plan Administration

The Plan Administrator, who is listed on the inside front cover of this brochure, is a named fiduciary under the Program and shall be responsible for the management and control of this Program.

The Plan Administrator is responsible for determining the level of benefits for the Program as described in this brochure. The Plan Administrator reserves the power at any and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the code or ERISA) to modify or amend, in whole or in part, any or all provisions of the Plan, provided, however, that no modification or amendment shall divest an employee of a right to those benefits to which he or she has become entitled under the Plan.

Funding Policy and Payment

The funding policy and method requires that the Group Subscriber submit payments on a monthly basis.

Procedure to Request Information

If you have any questions about this Program, contact the Plan Administrator who is listed in the inside front cover of this brochure.

Statement of ERISA Rights

As a participant in the Program, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine without charge at the Plan Administrator's office and at other specified locations such as work sites and union halls, all Plan documents, including insurance contracts, and copies of all documents such as detailed annual reports and Plan descriptions filed by the Plan with the U.S. Department of Labor.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Group, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your right, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court

costs and legal fees. If it finds your claim is frivolous, you will be responsible for these costs and fees. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

DELTA DENTAL OF NEBRASKA

FOR CLAIMS AND ELIGIBILITY

P.O. Box 245
Minneapolis, Minnesota 55440-0245
1-866-827-3319

FOR APPEALS

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

CORPORATE LOCATION

Atrium Executive Square
11235 Davenport Street, Suite 113
Omaha, Nebraska 68154
(402) 397-4878 or (800) 736-0710

Approved 4/2017
Updated 3/2017
Updated 1/2017
Approved 8/2016
Updated 6/2016
Approved 2/2015
Updated 12/2014
Updated 6/2014
Updated 4/2014
Updated 12/2013
Updated 4/2013
Approved 2/2013 (250 copies)