



DELTA DENTAL PREMIER®

BENEFITS CERTIFICATE



# INTERPRETING THIS BENEFITS CERTIFICATE

It is important that you understand all parts of this Benefits Certificate (Certificate) 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 other eligible Covered Persons who qualify for coverage under this Certificate. *We*, *us*, and *our* refer to Delta Dental of Iowa.

We will interpret the provisions of this Certificate 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 this Certificate we sometimes refer to certain laws and regulations. Laws and regulations can and do change from time to time. If you have a question as to how laws and regulations may apply to your coverage please contact your employer or group sponsor.

To administer your benefits properly, 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.

# TABLE OF CONTENTS

- SUMMARY OF BENEFITS AND PAYMENT .....6
- IMPORTANT INFORMATION.....7
  - WHAT YOU SHOULD KNOW ABOUT DELTA DENTAL DENTISTS .....7
  - WHAT YOU SHOULD KNOW ABOUT DENTISTS WHO DO NOT PARTICIPATE WITH DELTA DENTAL.....7
  - QUESTIONS WE ASK WHEN YOU RECEIVE DENTAL CARE .....8
  - OUR PAYMENT POLICY .....9
  - UNDERSTANDING PAYMENT VOCABULARY .....9
  - UNDERSTANDING AMOUNTS YOU PAY TO SHARE COSTS.....9
  - HELPING WHEN YOU HAVE QUESTIONS ..... 10
- BENEFITS ..... 11
  - CHECK-UPS AND TEETH CLEANING..... 11
  - CAVITY REPAIR AND TOOTH EXTRACTIONS..... 12
  - ROOT CANALS ..... 12
  - GUM AND BONE DISEASES ..... 13
  - HIGH COST RESTORATIONS ..... 14
  - DENTURES AND BRIDGES ..... 15
- SERVICES NOT COVERED ..... 15
- THE NOTIFICATION PROGRAM ..... 18
  - THE APPROVAL ..... 18
  - THE TREATMENT PLAN ..... 18
  - THE TREATMENT PLAN REVIEW ..... 18
- FILING CLAIMS ..... 18
  - WHEN TO FILE YOUR CLAIM..... 18
  - FILING WHEN YOU HAVE OTHER COVERAGE..... 19
  - APPEALING A DENIED CLAIM .....21
- YOUR CERTIFICATE .....22
  - ELIGIBILITY ENROLLMENT REQUIREMENTS .....22
  - ELIGIBILITY CHANGES.....22
    - QUALIFYING EVENTS.....22
  - COVERAGE ELIGIBILITY .....23
    - ELIGIBLE COVERED PERSONS.....23
    - TYPES OF COVERAGE.....23
    - QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO).....23
    - WHEN COVERAGE BEGINS .....24

WHEN COVERAGE ENDS.....	24
CONTINUED COVERAGE (COBRA).....	25
NOTIFICATION OF CHANGE .....	26
AUTHORIZED CERTIFICATE CHANGES .....	26
COVERAGE TERMINATION .....	26
EFFECTS OF TERMINATION.....	26
OUR RIGHT TO RECOVER PAYMENTS.....	27
PAYMENT IN ERROR.....	27
SUBROGATION .....	27
OTHER INFORMATION.....	27
YOUR ERISA RIGHTS .....	28

# 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.

	PREMIER	NON-PAR
<b>Deductible</b>	<b>\$50/\$150</b>	<b>\$75/\$225</b>
<b>Deductible Apply to Check-Ups and Teeth Cleaning</b>	<b>*No</b>	<b>Yes</b>
<b>Annual Maximum</b>	<b>\$1,000</b>	<b>\$1,000</b>
<b>Benefit Categories</b>	<b>Coinsurance</b>	
<b>Check-Ups and Teeth Cleaning</b> (Diagnostic and Preventive Services)		
1. Dental Cleaning		
2. Oral Evaluation		
3. Fluoride Applications	00%	20%
4. X-rays		
5. Sealant Applications		
6. Space Maintainers		
7. Maintenance Therapy		
<b>Cavity Repair and Tooth Extractions</b> (Routine and Restorative Services)		
1. Emergency Treatment		
2. General Anesthesia/Sedation	20%	40%
3. Restoration of Decayed or Fractured Teeth		
4. Limited Occlusal Adjustment		
5. Routine Oral Surgery		
<b>Posterior Composites</b> (Tooth colored filling on back teeth)	50%	60%
<b>Root Canals</b> (Endodontic Services)		
1. Apicoectomy		
2. Direct Pulp Cap	50%	60%
3. Pulpotomy		
4. Retrograde Fillings		
5. Root Canal Therapy		
<b>Gum and Bone Diseases</b> (Periodontal Services)		
1. Conservative Procedures	50%	60%
2. Complex Procedures		
<b>High Cost Restorations</b> (Cast Restorations)		
1. Cast Restorations		
a. Crowns	50%	60%
b. Inlays		
c. Onlays		
d. Posts and Cores		
<b>Dentures and Bridges</b> (Prosthetics)	50%	60%
1. Bridges	50%	60%
2. Dentures	20%	40%
3. Repairs and Adjustments		

\*Deductible for Benefit Category: Check-ups and Teeth Cleaning will be waived for Delta Dental Premier Dentists.

# 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 the 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 usually advantages when you receive services from Delta Dental Dentists.

Your payment responsibilities are also outlined in this section of your Certificate. How much you pay for Covered Services depends on the benefit category of the service you receive and the dentist you receive services from. It is most often to your financial advantage to receive services from a Delta Dental Dentist.

## WHAT YOU SHOULD KNOW ABOUT DELTA DENTAL DENTISTS

We have contracting relationships with Delta Dental Dentists throughout the state. Our contracts with Delta Dental 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 to you. When you receive services from Delta Dental Dentists who participate with Delta Dental of Iowa or any other Delta Dental Member Company, all of the following statements are true:

- Delta Dental Dentists agree to accept their local Delta Dental Member Company's payment arrangements, which may result in savings.
- Delta Dental Dentists agree to file claims for you.
- We settle claims directly with Delta Dental Dentists. You are responsible for any deductible and coinsurance amounts you may owe. See UNDERSTANDING AMOUNTS YOU PAY TO SHARE COSTS later in this section.
- Delta Dental Dentists agree to handle the notification program for you. See THE NOTIFICATION PROGRAM section.
- Delta Dental Dentists agree that he or she will only be paid the lesser of (i) his or her billed charge or (ii) Delta Dental's Maximum Plan Allowance for Covered Services. **Important:** This does not apply in the situation where a service otherwise qualifying as a Covered Service is provided and Delta Dental does not reimburse any part of such service. In such situation, the Delta Dental Dentist is not limited in the amount of the payment he or she may collect from you. See UNDERSTANDING PAYMENT VOCABULARY later in this section.

## WHAT YOU SHOULD KNOW ABOUT DENTISTS WHO DO NOT PARTICIPATE WITH DELTA DENTAL

When you receive services from nonparticipating (non-par) 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 contracting relationships with nonparticipating dentists and they do not agree to accept their local Delta Dental Member Company's payment arrangements. This means you are responsible for any difference between your nonparticipating dentist's billed charge and the Maximum Plan Allowance. See UNDERSTANDING PAYMENT VOCABULARY later in this section.
- Nonparticipating dentists are not responsible for filing your claims.
- We settle claims with you, not nonparticipating dentists. You are responsible for paying your dentist in full, including any deductible, coinsurance and non-approved charges you may owe. See UNDERSTANDING PAYMENT VOCABULARY later in this section.
- Nonparticipating dentists do not agree to handle the notification program for you. See THE NOTIFICATION PROGRAM section.

- Nonparticipating dentists 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.”)
- Nonparticipating dentists do not agree that he or she will only be paid the lesser of (i) his or her billed charge or (ii) Delta Dental’s Maximum Plan Allowance for Covered Services, as do Delta Dental Dentists in certain situations. See UNDERSTANDING PAYMENT VOCABULARY later in this section.

## QUESTIONS WE ASK WHEN YOU RECEIVE DENTAL CARE

Even though a procedure may appear in a given section such as 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; and
- The treatment is necessary to preserve or restore the basic form and 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; and
- The treatment is consistent with and meets professionally recognized standards of dental care and complies with criteria adopted by us; and
- 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 services which are more costly than those equally effective for the treatment or maintenance of your teeth and supporting structures, you are responsible for paying the difference.**

### Is the Procedure Subject to Contract Limitations?

Contract limitations refer to amounts that are your responsibility 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 SERVICES NOT COVERED.
- Amounts for procedures that have limitations associated with them. For example, routine teeth cleaning is covered twice per benefit period. More frequent teeth cleaning is not a benefit even if your dentist verifies that it is dentally necessary and dentally appropriate. See 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 BENEFITS AND PAYMENT chart at the beginning of this Certificate.
- Any difference between the dentist’s billed charge and the Maximum Plan Allowance, as the case may be. **Please note:** This only applies if you receive services from a nonparticipating dentist or services from a Delta Dental Dentist that are not reimbursed by Delta Dental to some extent.
- Deductible(s) and Coinsurance.



## 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 fixed or removable prosthesis when it is inserted.
- a root canal when it is filled.

## 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 deductible and 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 covered benefit under your Certificate*.

### Covered Person

Covered Person means any individual eligible for dental benefits under a dental program that is insured or administered by Delta Dental (or by a Delta Dental Member Company).

### Covered Services

Covered Services means dental services allowed as a result of being insured by, or included under a dental plan administered by, Delta Dental (or by a Delta Dental Member Company).

### Delta Dental Member Company

Delta Dental Member Company means a company that is an active member or affiliate member of Delta Dental Plans Association, as defined in the Delta Dental Plans Associations Bylaws.

### Maximum Plan Allowance

Maximum Plan Allowance is the amount which Delta Dental establishes as its maximum allowable fee for the dental services under the Delta Dental Premier Program. For services billed by dentists outside of Iowa, the Maximum Plan Allowance is based on information from that state's Delta Dental Member Company.

The Maximum Plan Allowance is established by Delta Dental for dental services contained in the “Current Dental Terminology” published by the American Dental Association from time to time. It is developed from various sources that may include, but are not limited to, contracts with dentists, the simplicity or complexity of the procedure, the billed charge for the same procedure by dentists in the same geographic area and with similar training and skills, and a leading economic indicator, such as the Consumer Price Index.

## UNDERSTANDING AMOUNTS YOU PAY TO SHARE COSTS

### Deductible

Deductible is the fixed dollar amount you pay for Covered Services for each Covered Person in a benefit period before benefits are available under this Delta Dental Certificate. This amount is shown on the SUMMARY OF BENEFITS AND PAYMENT chart at the beginning of this Certificate. **Please note:** The family deductible is reached from deductible amounts paid on behalf of any combination of Covered Persons.

**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 BENEFITS AND 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. In general, the percentage of coinsurance you pay depends on the benefit category of the service you receive.

**Benefit Period Maximum**

The benefit period maximum is the maximum benefit each Covered Person is eligible to receive for certain Covered Services in a benefit period. The benefit period maximum is reached from claims settled under this Certificate in a benefit period. This amount is shown on the SUMMARY OF BENEFITS AND PAYMENT chart at the beginning of this Certificate.

**Annual Maximum Carryover (To GO<sup>SM</sup>)**

Covered Persons may carry over any qualified, unused portion of their annual maximum benefit, subject to the following guidelines:

- The Covered Person must have been covered under the plan for the full benefit plan year, with coverage for major services.
- The Covered Person must have submitted at least one claim during the benefit plan year that would apply to his/her annual maximum where the allowed dollar amounts are greater than zero dollars.
- The rolled amount may not exceed the amount of the regular annual maximum, and the total combined annual maximum may not exceed twice the regular annual maximum.

**Other Payment Responsibilities**

In addition to the above, you will be responsible for any charge made by a dentist, even if it is a Delta Dental Dentist, where Delta Dental has not reimbursed to some extent any of the charge because you have not met any applicable waiting periods or deductibles and/or have exceeded any applicable benefit maximum or frequency limitation.

**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.

# BENEFITS

## CHECK-UPS AND TEETH CLEANING (DIAGNOSTIC AND PREVENTIVE SERVICES)

### Dental Cleaning (Prophylaxis)

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

*Limitation:* Routine dental cleaning is a benefit only twice per benefit period.

**Please Note:** Delta Dental of Iowa's Enhanced Benefits Program (EBP) offers up to 2 additional dental cleaning benefits for Covered Persons with designated dental or medical conditions. Total cleanings for qualifying participants in EBP are limited to no more than 4 per benefit period. For information regarding the dental or medical conditions that may qualify you for additional cleanings, visit Delta Dental's website, or contact Delta Dental. For your convenience, we have listed our toll-free number on the back cover of this Certificate. If you qualify for additional cleaning(s), it is your responsibility to register at Delta Dental's website, [www.deltadentalia.com](http://www.deltadentalia.com) or call Delta Dental of Iowa.

### Oral Evaluations

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

### Topical Fluoride Applications

*Limitation:* Topical fluoride is a benefit for eligible children under age 15 once per benefit period.

**Please Note:** Delta Dental of Iowa's Enhanced Benefits Program (EBP) offers topical fluoride applications as a benefit for all other eligible Covered Persons once per benefit period only when a qualifying dental or medical condition is present. For information regarding the dental or medical conditions that may qualify you for topical fluoride applications, visit Delta Dental's website or contact Delta Dental. For your convenience, we have listed our toll-free number on the back cover of this Certificate. If you qualify for topical fluoride applications, it is your responsibility to register at Delta Dental's website, [www.deltadentalia.com](http://www.deltadentalia.com).

### X-Rays:

#### Bitewing X-Rays

*Limitation:* Bitewing x-rays are a benefit for eligible children under age 15 once every 12 consecutive months.

*Limitation:* For eligible Covered Persons age 15 and greater, bitewing x-rays are a benefit once every 24 consecutive months if there is no history of restorations in the previous 24 months. If there is a history of restorations in the previous 24 months, bitewing x-rays are a benefit once every 12 consecutive months.

#### 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 5 consecutive years of the panoramic x-ray.

*Limitation:* Full-mouth x-rays are a benefit only once every 5 consecutive years.

#### Occlusal and Extraoral X-Rays

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

**Periapical X-Rays**

A radiographic image of a tooth, or limited number of teeth, that includes the crown and root portions.

**Sealant/Preventive Resin Applications**

Filling decay-prone areas of the chewing surface of molars.

*Limitation:* Sealant/Preventive Resin applications are a benefit once per permanent first and second molars for eligible children age 19 and younger.

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

**Space Maintainers for Missing Back Teeth**

*Limitation:* Space maintainers are a benefit only for eligible children under age 15.

**CAVITY REPAIR AND TOOTH EXTRACTIONS  
(ROUTINE AND RESTORATIVE SERVICES)****Emergency Treatment (Palliative Treatment)**

Treatment to relieve pain or infection of dental origin.

**General Anesthesia/Sedation**

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

**Restoration of Decayed or Fractured Teeth**

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

**Limited Occlusal Adjustment**

Reshaping the biting surfaces of one or more teeth.

*Limitation:* Limited Occlusal Adjustment is a benefit only twice every 12 consecutive months.

**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.

**ROOT CANALS  
(ENDODONTIC SERVICES)****Apicoectomy/Periradicular Surgery**

Surgery to repair a damaged root as part of root canal therapy or to correct a previous root canal.

**Direct Pulp Cap**

Covering exposed pulp with a dressing or cement to protect it and promote healing and repair.

**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.

**Retrograde Fillings**

Sealing the root canal by preparing and filling it from the root end of the tooth.

### **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:* Certain procedures in this category should receive our review *before* they are performed. See THE NOTIFICATION PROGRAM section.

#### **Full Mouth Debridement**

*Limitation:* Full mouth debridement is a benefit once in a lifetime after 36 months have elapsed since last dental cleaning (prophylaxis).

#### **Guided Tissue Regeneration**

Services and supplies for regeneration of lost periodontal structures.

#### **Conservative 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 of the mouth.

#### **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 every 36 consecutive months 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.

#### **Periodontal Maintenance Therapy**

Includes 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 in the first 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.*

**Please Note:** Delta Dental of Iowa's Enhanced Benefits Program (EBP) offers up to 2 additional dental cleaning benefits for Covered Persons with designated dental or medical conditions. Total cleanings for qualifying participants in EBP are limited to no more than 4 per benefit period. For information regarding the dental or medical conditions that may qualify you for additional cleanings, visit Delta Dental's website, or contact Delta Dental. For your convenience, we have listed our toll-free number on the back cover of this Certificate. If you qualify for additional cleaning(s), it is your responsibility to register at Delta Dental's website, [www.deltadentalia.com](http://www.deltadentalia.com) or call Delta Dental of Iowa.

#### **Localized Delivery of Chemotherapeutic Agents**

*Limitation:* This benefit is for non-responding sites following periodontal therapy and is limited to one service per tooth with a maximum of two teeth in a 24 consecutive month period.

## **HIGH COST RESTORATIONS (CAST RESTORATIONS)**

*Please note:* Certain procedures in this category should receive our review *before* they are performed. See THE NOTIFICATION PROGRAM section.

Procedures in this category are available once every 5 consecutive years beginning from the date the cast restoration is cemented in place.

### **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.

### **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, abrasion, erosion, and abfraction are not a benefit.

*Limitation:* Crowns are a benefit only if the tooth cannot be restored with a routine filling. Dental Implant benefits, including placement, restorative, and associated services will be limited to the amount paid for a conventional natural teeth supported prosthesis.

### **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.**

### **Onlays**

Replacing one or more missing or damaged biting cusps of a tooth with a cast restoration.

### **Posts and Cores**

Preparing a tooth for a cast restoration after a root canal when there is insufficient strength and retention.

### **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:* Certain procedures in this category should receive our review *before* they are performed. See THE NOTIFICATION PROGRAM section.

*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 Implant benefits, including placement, restorative, and associated services will be limited to the amount paid for a bridge as a replacement for up to two bounded and adjacent missing teeth. Fixed bridges and removable cast partials are not a benefit for Covered Persons under the age of 16 years.

### 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 Implant benefits, including placement, restorative, and associated services will be limited to the amount paid for a denture as a replacement of multiple and/or non-adjacent missing teeth.

### Denture Adjustments

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

### Tissue Conditioning

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

## SERVICES NOT COVERED

This Delta Dental Certificate 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. For your convenience, we have listed our toll-free number on the back cover of this Certificate.

### CERTIFICATE EXCLUSIONS

#### Anesthesia or Analgesia

You are not covered for local anesthesia or nitrous oxide (relative analgesia) when billed separately from the related procedure.

#### Broken Appointments

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

**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.

**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.

**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.

**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.

**Desensitizing Medicament or Resin**

You are not covered for the application of desensitizing medicament or resin for cervical and/or root surface sensitivity either on a per tooth or per visit basis.

**Drugs**

You are not covered for prescription, non-prescription drugs, or medicines or therapeutic drug injections.

**Effective Date**

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

**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).

**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.

**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**

You are not covered for 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 Certificate, 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, Replacement or Duplication of Orthodontic Appliances**

You are not covered for services or supplies required to repair, replace or duplicate any orthodontic appliance.

**Services Not Reimbursed to Some Extent by Delta Dental**

You are not covered for any service that otherwise would qualify as Covered Service but which Delta Dental does not reimburse to some extent. This may include services not reimbursed because of applicable deductibles, copayments, coinsurance, benefit maximums, waiting periods, and frequency limitations.

**Services Provided in Other Than Office Setting**

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

**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 anyone 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.

## **THE NOTIFICATION PROGRAM**

This section explains the notification program you or your 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:

- 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:

**Complex Periodontal Surgery**

**High Cost Restorations including Crowns, Onlays, and Bridges**

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 Certificate 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-rays within 15 working days of receipt of the proposed treatment plan.

## 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 9000  
Johnston, IA 50131-9000*

## 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 Certificate;
  - 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.

## 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.

### 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](http://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 9000  
Johnston, IA 50131-9000*

## **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 Certificate 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 need to 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 should:

- 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. We will contact you 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 coverages are through a group sponsor such as an employer, but one coverage has coordination of benefits and one does not.
- 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 contract holder* pays before the coverage which you have as a spouse or 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 or to your Delta Dental Dentist.

## **What You Should Know About Children**

To coordinate benefits for a 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 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.

## **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 your name, patient's name and your 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 our written decision and indicate any action we 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 we 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 a.m. to 4:30 p.m., Central Standard Time, Monday through Friday, at Delta Dental of Iowa's Johnston, Iowa location. Since so many records are electronically filed, please call Delta Dental of Iowa in advance so we can have copies ready for you.

**Send your request to:**

*Delta Dental of Iowa  
P.O. Box 9010  
Johnston, Iowa 50131-9010  
or call 1-800-544-0718*

# 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 we have with your employer or group sponsor, any application completed by your employer or group sponsor, this Certificate, and any riders or amendments. 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 to us, upon which we may rely. We will not use the statements to deny any claim unless we've furnished you with a copy of the statement.

## ELIGIBILITY ENROLLMENT REQUIREMENTS

This benefit plan includes the following eligibility requirements:

- You must apply for coverage when initially eligible or due to a Qualifying Event
- If you do not apply for coverage when initially eligible you will not be eligible to enroll in this Plan until your employer or group sponsor's next Anniversary Date; unless the election is due to a Qualifying Event
- If you drop coverage you will not be eligible to re-enroll in this Plan, until your employer or group sponsor's next Anniversary Date; unless the election is due to a Qualifying Event

## ELIGIBILITY CHANGES QUALIFYING EVENTS

Certain events may require you to change who is covered by this Certificate. These events include:

**Active Duty in the Military** of an eligible Child or Spouse

**Appointments as a Legal Guardian** of a Child

**Birth or Adoption** of a Child

**Care of a Foster Child** (when placed in your home by and approved agency)

**Completion of Full-time Schooling** of an eligible Child age 26 or older

**Death**

**Divorce, Annulment, or Legal Separation**

**Eligible Child** (who is *not* a full-time student or permanently disabled) reaches age 26

**Exhaustion of COBRA Coverage**

**Marriage**

**Spouse of Child Loses Eligibility for Qualifying Dental Coverage** or employer or group sponsor ceases contribution to qualifying dental coverage. In this case, your eligible Spouse and any eligible Children previously covered under the prior qualifying dental coverage are eligible for coverage under this certificate.

**Spouse's Medicaid, or Child's Medicaid or Children's Health Insurance Program (CHIP) or Healthy And Well Kids in Iowa (hawk-i)** coverage is terminated as a result of losing eligibility or the Eligible Covered Person becomes eligible for a premium assistance subsidy under Medicaid or CHIP. This special enrollment opportunity is provided by the Children's Health Insurance Program Reauthorization Act (CHIPRA). You must request this special enrollment opportunity within 60 days of losing Medicaid, CHIP, or hawk-I coverage or within 60 days of when eligibility for the premium assistance is determined.

## **COVERAGE ELIGIBILITY ELIGIBLE COVERED PERSONS**

An eligible Covered Person is an employee who has met the employer's eligibility requirements and the employee's eligible spouse or eligible child(ren).

Spouse means your husband or wife as the result of a marriage that is legally recognized in Iowa. Some employer groups recognize domestic partners as eligible Covered Person(s). An eligible 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. Children must meet at least one of the following standard requirements to be an eligible child:

- The child is under age 26.
- The child is age 26 or older, not married, and a full-time student. For an eligible child to be considered a full-time student they must be enrolled in an accredited institution of higher learning, such as a college, university, nursing, or trade school, and carry enough hours to be classified by the institution as full-time. 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.
- The child is a dependent of the child's parent and is totally or permanently disabled, either physically or mentally. If the dependent child is permanently disabled, the disability must have existed before the child was age 19 or while the child was a full-time student under 26 years of age, and the child must have had continuous qualifying dental coverage without a break of 63 days or more since the child turned age 19 or while the child was a full-time student under age 26.

A 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.

## **TYPES OF COVERAGE**

There are different categories of coverage you may hold under this Certificate:

- With *single coverage*, you are the only one covered.
- With *family coverage*, you, your eligible spouse, and each of your eligible children are covered. Each eligible Covered Person must be listed on your dental application for coverage or added later as a new eligible Covered Person.

## **QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)**

If you have a 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 child that the order has been received. Your employer also will inform you and the child of the employer's procedures for determining whether the order is a Qualified Medical Child Support Order. You may obtain, without charge, a copy of QMCSO procedures from your employer or group sponsor.

## **WHEN COVERAGE BEGINS**

Your coverage under this Certificate begins on your effective date. If you have just started a new job, check with your employer or group sponsor to find out your effective date.

**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 healthcare provider or his or her 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 identification card or misrepresent or conceal material facts in your application, then we may terminate your benefits.

## **WHEN COVERAGE ENDS**

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

- You become ineligible for coverage under this Certificate. See *Eligible Covered Persons* earlier in this section.
- You become unemployed. Termination of your coverage for this reason applies only if you receive your coverage through your employer or group sponsor.
- Your employer or group sponsor decides to discontinue or replace this coverage.
- We decide to terminate coverage of all similar Certificates by giving written notice to your employer or group sponsor 90 days prior to termination.

Your coverage will end if any 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 fail 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 (COBRA)**

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

### **Coverage Continuation Under Federal Law — COBRA**

The Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to employers with 20 or more employees. COBRA entitles you, your eligible spouse and your eligible children to a continuation of coverage under this Certificate if coverage is lost due to any of the following qualifying events:

- Death of the employee covered under this Certificate.
- Termination of employment for reasons other than gross misconduct.
- A reduction in hours causing loss of coverage.
- Divorce or legal separation.
- The employee covered under this Certificate becomes entitled to Medicare.
- Child/Children are no longer considered eligible by our eligibility rules.
- The employer from whom the covered employee retired files bankruptcy under federal law (in certain cases).

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

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 to your employer for the continuation of this Certificate. Depending on how you qualify, you may continue your coverage for up to 18 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 eligible Covered Person(s) who have 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, your eligible spouse, and/or eligible 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.
- 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 other 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.
- The date the qualified beneficiary is entitled to Medicare benefits.

### **PREMIUMS**

You or your employer or group sponsor must pay us in advance of the due date assigned for your Certificate. For example, payment must be made prior to the beginning of each calendar month, each quarter, or each year, depending on your specific due date.

### **NOTIFICATION OF CHANGE**

You must notify us within 31 days of the date of the event that changes the status of your eligibility. Delta Dental of Iowa must be notified within 60 days of the date of the event that changes the status of your eligibility for births, adoptions or due to a change in eligibility status in Medicaid, CHIP or hawk-i. You can ask your employer or group sponsor to help you make this request. If a change to your eligibility is not made within 31 days of an event, the person(s) affected may lose important coverage.

### **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 as shown by payment of the monthly premium.
- *our receipt of proper notification* that your marital or eligibility status has changed and we receive an appropriate monthly premium in advance, then we will change your coverage to the correct coverage type. See *Types of Coverage* explained earlier in this section.

### **COVERAGE TERMINATION EFFECTS OF TERMINATION**

If your coverage is terminated for fraud, misrepresentation, or the concealment of material facts:

- *we will not pay* for any services or supplies provided after the date the 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 coverage void*.

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

## **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**

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 other eligible Covered Person(s) 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 Certificate;
- You will 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 other eligible Covered Person (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.

## **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 9010  
Johnston, IA 50131-9010*

Any notice from us to you is valid 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 your personal benefit and cannot be transferred or assigned to anyone else without our consent. Any attempt to assign this Certificate or rights to payment without our consent will be void.

## **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 Certificate will be litigated exclusively 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.

## **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 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.

### **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.

# **YOUR ERISA RIGHTS**

Your rights concerning your coverage may be protected by the Employee Retirement Income Security Act of 1974 (ERISA). Any employee benefit plan established or maintained by an employer or by an employee organization or both is subject to this federal law unless the benefit plan is a governmental or church plan as defined in ERISA. ***If ERISA applies to your group, you will want to read this section carefully.***

## **YOUR ERISA RIGHTS**

The Employee Retirement Income Security Act of 1974 (ERISA) provides that you will be entitled to:

- examine certain plan documents and copies of documents (such as annual reports) filed by the plan with the United States Department of Labor. You may examine these documents at the Plan Administrator's office or at specified locations. You will not be charged to examine these documents. The latest annual report is available at the Public Disclosure Room of the Employee Benefits Security Administration.
- obtain copies of certain plan documents from the Plan Administrator upon written request. The Plan Administrator may request a reasonable charge for the copies.
- receive a summary of the plan's annual financial report if your employer or group sponsor has 100 or more participants in your plan. The Plan Administrator is required by law to furnish you with a copy of this summary annual report.

### **The Responsibility of Your Employee Benefit Plan**

In addition to creating rights for you and other participants, ERISA imposes duties upon the people responsible for the operation of your plan. The people responsible are called *fiduciaries* of the plan. Fiduciaries have a duty to operate your plan prudently and in the interest of you, other plan participants, and your family beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a covered benefit or exercising your rights under ERISA. If your claim for a covered benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time requirements.

### **Steps You Can Take to Enforce Your Rights**

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request the plan document from the Plan Administrator and do not receive it within 30 days, a federal court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the document, unless the document was not sent because of matters reasonably 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 rights, 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 you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Who to Contact When You Have Questions**

If you have any questions about your plan, you should contact the Plan Administrator, i.e. your employer or group sponsor. If you have questions about this statement or about your rights under ERISA or HIPAA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Area Office of the Employee Benefits Security Administration, 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. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**Delta Dental of Iowa  
P.O. Box 9000  
Johnston, IA 50131-9000**

**Hearing Impaired Toll Free: 1-888-287-7312  
Toll Free: 1-800-544-0718  
Local: 1-515-261-5500**

**[www.deltadentalia.com](http://www.deltadentalia.com)  
[Claims@deltadentalia.com](mailto:Claims@deltadentalia.com)**