DELTA DENTAL®

Signature Plan
Delta Dental of Iowa

Benefits Certificate

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Hello!

You have dental insurance. That's great! All of us at Delta Dental of Iowa are happy we can help you have a healthy smile and better oral health in general.

This packet includes details about your coverage. We know insurance isn't usually an exciting topic. But reading this will help you better understand your benefits and get the most out of them.

For instance, you'll learn:

- Which kinds of dental services are covered and are not covered
- What part of the costs you pay and what part we'll pay
- Why seeing an in-network dentist could save you money
- How we decide what services are covered
- When to check with us before getting a service
- Other things that will help you get the most out of your benefits

So keep reading. You'll be glad you did. And if you have any questions about this Certificate or need to make a change, just give us a call at 877-423-3582, ext. 5, Monday through Friday or email us at TeamRenew@deltadentalia.com. If you have questions about a claim you can contact us at (800) 544-0718 or email us at Claims@deltadentalia.com.

Understanding this Certificate
Here are some things to keep in mind as you look over the Certificate.

Let's keep it casual
Insurance is complicated enough. So instead of saying "Eligible Covered Persons" all the time, we'll say *you* and *your* to refer to you and anyone else who's covered under this Certificate. And instead of saying "Delta Dental of Iowa," we'll say *we*, *us* and *our*.

Questions about what's covered
Sometimes questions arise about your Certificate. When that happens, we'll help you understand the benefits and the reasons for our decisions.

Keep in mind, we interpret the terms of this Certificate and make all decisions regarding coverage based on it. This includes deciding whether you meet our written eligibility requirements. If there are questions about whether a certain dental procedure is necessary and appropriate, we'll make the decision based on factual information. Our decisions are final and conclusive.

To obtain benefits under this Certificate there are certain procedures you must follow. These procedures appear in different sections of this Certificate, so keep reading so that you fully understand.

Sometimes laws change
In this Certificate, we refer to certain laws and regulations. These laws can and do change from time to time. If you have a question about the impact of laws and regulations on your Certificate, please contact us.

And finally…
This Certificate does not include all pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available with other Delta Dental of Iowa plans or is available in the Insurance Marketplace.

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Summary of benefits and payment

What part of your dental costs will you pay? This chart gives you a summary outline of the benefits provided and the payments for which you are responsible. For details, go to the Benefits section. One quick note — "Non-par" in these charts means Non-Participating Dentists. Those are dentists who have chosen not to participate in the Delta Dental network.

You receive benefits from the categories below:	From a type of dentist below	You pay the applicable deductible for the benefits? (Yes/No)	You pay the Coinsurance percentage below	The benefits used count against the Benefit Period Maximum? (Yes/No)
Benefit Categories	**Type of Network**	**Your Deductible***	**Member Coinsurance****	**Benefit Period Maximum or Annual Maximum*****
	PPO	$25		$2,000
	Premier	$50		
	Non-par	$75		
Check-ups and teeth cleanings (Diagnostic and Preventive)	PPO	No	00%	Yes
	Premier	No	00%	Yes
	Non-par	No	10%	Yes
Cavity repair and tooth extractions (Routine and Restorative Services)	PPO	Yes	20%	Yes
	Premier	Yes	30%	Yes
	Non-par	Yes	50%	Yes
Posterior composite(s) (Tooth-colored filling(s) on back teeth)	PPO	Yes	40%	Yes
	Premier	Yes	50%	Yes
	Non-par	Yes	60%	Yes
Root canals (Endodontic Services)	PPO	Yes	40%	Yes
	Premier	Yes	50%	Yes
	Non-par	Yes	60%	Yes
Gum and Bone Disease (Periodontal Services)	PPO	Yes	40%	Yes
	Premier	Yes	50%	Yes
	Non-par	Yes	60%	Yes
High-cost restorations (Restorations)	PPO	Yes	50%	Yes
	Premier	Yes	50%	Yes
	Non-par	Yes	60%	Yes
Dentures and bridges (Prosthetics)	PPO	Yes	50%	Yes
	Premier	Yes	50%	Yes
	Non-par	Yes	60%	Yes
Dental implants (Prosthetics)	PPO	Yes	50%	Yes
	Premier	Yes	60%	Yes
	Non-par	Yes	70%	Yes
Additional Optional Benefits Included Annual Maximum Carryover (To Go℠) Enhanced Benefits Program				

*Deductible is per person, paid once per Benefit Period.
**Member Coinsurance is the percent of costs *you pay* each time you receive certain covered services.
***Benefit Period Maximum or Annual Maximum is the maximum dollar amount *we'll pay* for all Covered Services for each Covered Person under the Policy in a Benefit Period.

Important information

We've designed this Certificate to encourage you and your family to get regular, preventive dental care. That helps to keep your teeth healthy. And it helps to control costs—for you and for us.

A big part of this program is our network of dentists. Our network consists of:

- PPO Panel Dentists; and
- Premier Panel Dentists

Of course, you can see just about any dentist you want. But there are usually some pretty big advantages for you—like cost savings—when you see a PPO Panel Dentist or Premier Panel Dentist. Together, these two groups of dentists make up our Delta Dental Participating Dentist network. Regardless of your dentist's physical location, if your dentist participates with Delta Dental, they are participating with Delta Dental of Iowa.

Generally, you'll save the most when you see PPO Panel Dentists.

The majority of dentists in the U.S. are either PPO Panel Dentists or Premier Panel Dentists. Some dentists, though, choose not to participate in our network. We refer to them as **Non-Participating Dentists**.

How much you pay for Covered Services depends on the benefit category of services you receive and the dentist you receive services from. See the **Summary of Benefits and Payment** charts for an outline of your payment when you see a PPO Panel Dentist, Premier Panel Dentist or a Non-Participating Dentist.

What you should know about PPO Panel Dentists

We have contracts with PPO Panel Dentists throughout the state. These contracts subject the dentist to our applicable fee schedule or Maximum Plan Allowance. See **Understanding terms and amounts you pay to share costs** section for a definition of the Maximum Plan Allowance.

When you see PPO Panel Dentists:

- They've agreed to accept Delta Dental's PPO Fee Schedule. This usually means cost savings for you for covered services.
- Your Deductible or Member Coinsurance may be less for covered services than if you see a Premier Panel Dentist or a Non-Participating Dentist.
- They've agreed to file claims for you, and we settle claims directly with them. This means less paperwork and fewer phone calls for you.
- They've agreed to handle the Pre-Treatment Estimate for you. See Pre-Treatment Plan Estimate section for more information.
- They've agreed they'll be paid the lesser of (i) their Billed Charge or (ii) our applicable fee schedule or (iii) the Maximum Plan Allowance for Covered Services. (Keep in mind, this doesn't apply in situations where we don't pay for any part of a service. For example, when you haven't met a Waiting Period or your Deductible, and/or if you've gone over your Benefit Period Maximum.) In these situations, the PPO Panel Dentist is not limited in the amount of payment they may collect from you. See Definitions of common payment terms section later in this section.

What you should know about Premier Panel Dentists

We have contracts with Premier Panel Dentists throughout the state. These contracts include payment arrangements based on Dental Dental's applicable fee schedule or on our Maximum Plan Allowance, which usually results in savings for you.

When you see Premier Panel Dentists:

- They agree to accept the Delta Dental Maximum Plan Allowance. This could mean savings for you for Covered Services.
- Your Deductible or Member Coinsurance may be *more* for Covered Services than if you saw a PPO Panel Dentist. But you'll pay less than if you saw a Non-Participating Dentist.
- They've agreed to file claims for you, and we settle claims directly with them. This means less paperwork and fewer phone calls for you.
- They've agreed to handle the Pre-Treatment Estimate for you. See the **Pre-Treatment Plan Estimate** section for more information.
- They've agreed that they'll be paid the lesser of (i) their Billed Charge or (ii) our Maximum Plan Allowance for Covered Services. (Keep in mind that this doesn't apply in situations where we don't pay for any part of a service. For example, when you haven't met the Waiting Periods or Deductibles, and/or if you've gone over your Benefit Period Maximum.) In these situations, the Premier Dentist is not limited in the amount of payment they may collect from you.

Finding a Provider Near You

By visiting www.deltadental.com/member/find-a-dentist/ you can locate an in-network dentist in your area by using your location or manually entering your ZIP code.
You can search for a provider by:

- Specialty
- Plan Network
- Dentist's Last Name

What you should know about Non-Participating Dentists

Non-Participating (non-par) dentists are those who've chosen not to join a Delta Dental network. That means there's no contract or payment arrangement in place with these dentists, so you won't get the advantages that our participating dentists offer, like lower fees.

When you see Non-Participating Dentists:

- They haven't agreed to accept their local Delta Dental Member Company's PPO payment arrangement or any other payment arrangement. They can charge whatever they want.
- You're responsible for any difference between the dentist's Billed Charge and the Delta Dental Non-Participating Dentist fee schedule.
- They're not responsible for filing your claims or settling your claims with us. That means you'll need to take care of any paperwork and phone calls about your claims.
- We settle claims with you, not the Non-Participating Dentist. However, for Iowa Non-Participating Dentists, the payment will be mailed to you, but the check may be payable to the Non-Participating Dentist. You are responsible for paying your dentist in full. This includes any Deductible, Member Coinsurance and non-approved charges you may owe.
- They don't agree to handle the Pre-Treatment Estimate for you. See **Pre-Treatment**

Plan Estimate section for more information.
- Non-Participating Dentist may charge for "infection control." This includes the cost for services and supplies associated with sterilization procedures. You're responsible for these extra charges. (All dentists are legally required to follow certain infection control guidelines. But PPO Panel Dentists and Premier Panel Dentists incorporate these costs into their normal fees—so they don't charge an extra fee for infection control.)

Keeping an eye on quality and cost

Although a procedure may be listed in a given section as a Benefit, it is important to note that before you are eligible to receive benefits, we first answer the following questions. This helps us ensure you are receiving the right dental care and at the right cost. We ask:

Is the procedure Dentally Necessary?
Both of these must be true for the procedure to be 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 this must be true for the procedure to be Dentally Appropriate:
- The treatment is the most appropriate for your situation and
- The treatment meets professionally recognized standards of dental care, and complies with our clinical criteria and
- The treatment doesn't cost more than other procedures that would be equally effective for the treatment or maintenance of your teeth and their supporting structures. (If this isn't the case, you're responsible for paying the difference. This applies to any services provided).

Do contract limitations apply?
Contract limitations are amounts that are your responsibility based on your Certificate with us. Here are some examples:
- Amounts for procedures that aren't dentally necessary or dentally appropriate.
- Amounts for procedures that aren't covered by this Certificate.
- Amounts for procedures that have frequency or dollar limits (For example, teeth cleanings are covered twice per Benefit Period. Additional teeth cleaning may not be covered—even if your dentist says it's 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** charts at the beginning of this Certificate.
- Any difference between the dentist's Billed Charge and the applicable fee schedule, or the Maximum Plan Allowance. This only applies:
    - If you receive services from a Non-Participating Dentist, or
    - To procedures that aren't Covered Services, or
    - To services from a PPO Panel Dentist or a Premier Panel Dentist that aren't paid by us to some extent, or
    - To Deductible(s) and Member Coinsurance.

Our payment policy

We send payment after the treatment is complete —not before. For example, we'll send our payment for:

- A crown when it's seated or placed.
- A fixed or removable prosthesis when it's inserted.
- Dentures when delivered.
- A root canal when it's filled.

Definitions of common payment terms

We work with insurance all the time. But you probably don't. So, let's make sure we're on the same page when we talk about your benefits and payments. These definitions will help.

Anniversary Date
The Anniversary Date is the renewal date of the contract between your employer or group sponsor and Delta Dental of Iowa.

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. We use your Benefit Period to calculate your Deductible and Benefit Period Maximum, if applicable.

Billed Charge
The Billed Charge is the amount a dentist bills for a specific dental procedure.

Contract Period Effective Date
The Contract Period Effective Date is the first day the dental coverage was in effect between your employer or group sponsor and Delta Dental of Iowa.

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

An **Adult** Covered Person may be:

- You, the eligible employee
- Your eligible Spouse or Domestic Partner
- An adult child who is age 21 and under age 26 as of your employer or group sponsor's Anniversary Date
- An adult child who is age 26 or older, not married, and a full-time student as of your employer or group sponsor's Anniversary Date. For an eligible Adult 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.

- An adult child who is age 21 or older as of your employer or group sponsor's Anniversary Date and is a dependent of the Child's parent and is totally or permanently disabled, either physically or mentally. If the dependent Child or Adult Child is permanently disabled, the disability must have existed before the Child was age 19 or while the Adult Child was a full-time student under 26 years of age, and the Adult 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 Adult Child was a full-time student under age 26.

Spouse means your husband or wife as the result of a marriage that's legally recognized in Iowa. Some employers or group sponsors recognize a domestic partner as a Covered Person.

A Domestic Partner is a person who:
- Has shared a permanent residence with you for more than one year
- Is at least 18 years old
- Isn't a blood relative any closer than would prohibit legal marriage in Iowa

A **Child** Covered Person is under age 21 as of your employer or group sponsor's Anniversary Date and may be:
- Your natural child
- A child placed with you for adoption
- A legally adopted child
- A child for whom you have legal guardianship
- A stepchild
- A foster child

A soon-to-be or previously adopted child is eligible for coverage as of the date of placement for adoption, the date of the issuance of a final decree or upon an interlocutory adoption decree becoming a final adoption decree, whichever occurs first.

Covered Services
Covered Services means dental services allowed under a dental plan administered by us.

Delta Dental Member Company
A company that's 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 we establish as the maximum allowable fee for certain Covered Services provided by Premier Panel Dentists. For services billed by Premier Panel Dentists outside of Iowa, the Maximum Plan Allowance is based on information from that state's Delta Dental Member Company.

We establish the Maximum Plan Allowance for dental services contained in the "Current Dental Terminology," book published by the American Dental Association. Several factors are taken into consideration, including but 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,

with similar training and skills
- Leading economic indicators, like the Consumer Price Index

PPO Schedule
The PPO Schedule is a reduced fee schedule used to pay PPO Panel Dentists for certain Covered Services. This is what helps you save money on your dental care.

Understanding the terms and amounts you pay to share costs.

Deductible
Deductible is the dollar amount you pay for Covered Services for each Covered Person in a Benefit Period before benefits are available under this Certificate (or, in other words, before we start paying under the Certificate). This amount is shown on the **Summary of Benefits and Payment** charts at the beginning of this Certificate.

Please note: The Deductible is paid once, per Covered Person, each Benefit Period.

Member Coinsurance
Coinsurance is the sharing of dental expenses between Delta Dental and you. The Member Coinsurance is the percentage of the dental expense you pay each time you receive certain Covered Services. The Member Coinsurance amounts are shown on the **Summary of Benefits and Payment** charts at the beginning of this Certificate.

Your coinsurance starts once you fulfill your deductible (if one applies). It's calculated based on the applicable fee schedule. In general, your coinsurance percentage depends on the benefit category of the service you receive and the participation status of your dentist.

Benefit Period Maximum or Annual Maximum
The Benefit Period Maximum or Annual Maximum is the maximum amount we may pay for each Covered Person for all Covered Services in a Benefit Period. No further benefits are payable once the Benefit Period Maximum or Annual Maximum has been met. This amount is shown on the **Summary of Benefits and Payment** charts at the beginning of this Certificate, if applicable.

Services received from **Benefit Category: Straighter Teeth** are excluded from your Benefit Period Maximum or Annual Maximum.

Other payment responsibilities
In addition to the above, you will be responsible for paying dental care charges when Delta Dental does not make any payment because you have not exhausted your Waiting Period, paid your Deductible or Member Coinsurance, or have exceeded your Benefit Period Maximum, or frequency limitations. This is the case even when a PPO Panel Dentist or Premier Panel Dentist provided the services.

Annual Maximum Carryover (To Go℠)
A Covered Person may carry over any qualified, unused portion of their Annual Maximum Benefit from the prior Benefit Period, subject to the following guidelines:

- A Covered Person that was not covered for the full Benefit Period immediately preceding the current Benefit Period may receive a prorated award based on the beginning date of their benefit coverage.
- A Covered Person must have submitted at least one claim during the Benefit Period that would apply to his/her Annual Maximum where the allowed dollar amounts are greater than zero dollars.
- The Carried over 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.

Enhanced Benefits Program (EBP)
The Enhanced Benefits Program offers additional oral health services to Covered Persons with qualifying dental or medical conditions. Qualifying participants may be eligible for:

- Additional cleanings
- Topical Fluoride Application

For information regarding the dental or medical conditions that may qualify you for additional cleanings and/or topical fluoride applications visit Delta Dental of Iowa's website, www.deltadentalia.com, or call us. See **Benefits** section for additional information.

If you qualify, it is your responsibility to register for the additional dental benefits.

Special Health Care Needs
People with special health care needs may be eligible for additional services including unlimited exams, up to 4 hygiene visits per calendar year, dental case management, and sedation/anesthesia. Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, healthcare intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

Help when you have questions
If you have questions after reading this Certificate, please call using the contact information on the back cover of this Certificate.

Benefits

Check-ups and teeth cleaning (Diagnostic and Preventive Services)		
Benefit	Description	Limit (if any)
Dental Cleaning (Prophylaxis)	Removing plaque, tartar (calculus) and stain from teeth and implants.	This procedure is a benefit 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 of Iowa's website, or contact us. 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 of Iowa's website, **www.deltadentalia.com**, or call us.
Oral Evaluations	A dental exam that includes checking for cavities, gum disease and any other concerns in the mouth, face, and neck that are related to the oral cavity.	This procedure is a benefit three times per Benefit Period. This includes all dental exams including preventative, comprehensive, consultations and problem focused exams.
Topical fluoride applications	Professional administered procedure in which the dental surfaces are coated with a fluoride solution or gel to help prevent decay.	The procedure is a benefit only for eligible children under age 19 twice per Benefit Period. Please note: Delta Dental of Iowa's Enhanced Benefits Program (EBP) offers topical fluoride applications as a benefit

		for a Covered Person twice per Benefit Period only when a qualifying dental or medical condition is present. An exception to this is for members receiving cancer-related chemotherapy and/or radiation. These members may receive fluoride treatments up to four times per benefit period. For information regarding the dental or medical conditions that may qualify you for topical fluoride applications, visit Delta Dental of Iowa's website or contact us. 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 of Iowa's website, **www.deltadentalia.com**, or call us.
Bitewing X-Rays	Shows the crowns of the upper and lower teeth at the same time; held in place by a tab between the teeth.	For eligible children under age 15 as of the Anniversary Date, this procedure is a benefit once every 12 consecutive months. For an Eligible Covered Person who is age 15 or older, this procedure is 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.
Cone Beam CT X-Rays	Produce a three-dimensional (3-D) scan of teeth, soft tissues, nerve pathways and bone in a single scan.	This procedure is a benefit once per Benefit Period.
Full-Mouth X-Rays	Combination of individual x-rays taken by a dentist on the same service date.	This procedure is a benefit once every five consecutive years. Note: A panoramic x-ray is a benefit if full-mouth x-rays

		haven't been done within five (5) years of the panoramic x-ray.
Occlusal x-rays	Capture all upper and lower teeth in one image; the film rests on the biting surface of the teeth.	This procedure is a benefit once every 12 consecutive months.
Periapical x-rays	A radiographic image of a tooth (or some teeth) that shows the crown and root portions.	
Periodontal-Maintenance Therapy	A dental cleaning that is deeper than a regular cleaning, but for people with a history of periodontal (gum) disease and treatment of that gum disease.	To qualify as covered Periodontal Maintenance Services, maintenance services should follow Non-surgical or Surgical periodontal therapy. This benefit is available: Up to four times in the first Benefit Period following the initial periodontal therapy and twice per Benefit Period after that. This procedure takes the place of the dental cleaning benefit (prophylaxis) described under check-ups and teeth cleaning. Please note: Delta Dental of Iowa's Enhanced Benefits Program (EBP) offers up to 2 additional dental cleaning benefits for a Covered Person 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 of Iowa's website, or contact us. 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 of Iowa's website, **www.deltadentalia.com**, or call us.
Sealant/preventive resin applications	A thin plastic coating on the cavity prone surfaces of molar teeth.	These procedures are a benefit once per permanent first and second molars every 24 months for eligible children under age 19. This is not a benefit for primary teeth, wisdom teeth or teeth that have already been treated with a restoration.
Space maintainers for missing back teeth	Passive appliances designed to prevent tooth movement.	Space maintainers are a benefit only for eligible children under age 15.

Cavity repair and tooth extractions (Routine and Restorative Services)		
Benefit	Description	Limit (if any)
Emergency Treatment (Palliative Treatment)	Treatment used in an emergency situation to relieve pain, swelling, bleeding or infection caused by a dental problem.	
General Anesthesia/Sedation	A combination of medications used to put you in a sleep-like state before and during surgery.	This procedure is a benefit only when done with a covered oral surgery and billed by the operating dentist.
Restoration of Decayed or Fractured Teeth	Restorations such as silver (amalgam) fillings and tooth-colored (composite) fillings. This also includes pre-formed or stainless-steel restorations.	Restorations are a benefit once every 24 months per tooth.
Limited Occlusal Adjustment	Reshaping the biting surfaces of one or more teeth.	This procedure is a benefit twice every 12 consecutive months.
Routine Oral Surgery	Includes removal of teeth and other surgical services to the teeth or immediate surrounding hard and soft tissues; surgery must be due to disease, pathology or dysfunction of a dental origin.	

Root Canals (Endodontic Services)		
Benefit	Description	Limit (if any)
Apicoectomy/Periradicular Surgery	Surgery to repair a damaged root 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; generally involves removing the pulp and replacing it with an inert filling material.	

Gum and Bone Diseases (Periodontal Services) Note: Some of these procedures should receive our review before they're performed. To learn more about the review process, see the Pre-Treatment Plan Estimate section.		
Benefit	Description	Limit (if any)
Alveoloplasty	Surgery for recontouring supporting bone—usually in preparation of a denture.	
Athletic Mouth Guard	An athletic mouth guard is a resilient intraoral device worn during participation in contact sports to reduce the potential for injury to the teeth and associated tissue.	An athletic mouth guard is a benefit for all eligible Covered Persons under age 19 once every 24 consecutive months.
Full Mouth Debridement	Preliminary removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation.	This procedure is a benefit once in a lifetime after 36 months have elapsed since your last dental cleaning (prophylaxis).
Guided Tissue Regeneration	Services and supplies for regeneration of lost	

	periodontal structures.	
Non-Surgical Periodontal Treatment (Root Planing and Scaling)	Deep cleaning procedure to remove dental plaque and calculus for those with gum disease which normally includes loss of the supporting bone structure.	This procedure is a benefit once every 24 months for each quadrant of the mouth.
Surgical Periodontal Procedures	Various surgical interventions designed to repair and regenerate gum and bone tissues that support the teeth.	This procedure is a benefit once every 36 months for each tooth or 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; it includes four or more teeth or bounded (contiguous) teeth spaces in a row.
Localized Delivery of Chemotherapeutic Agents	The administration of a time-released antibiotic to eliminate infectious bacteria from areas below the gumline for those with advanced gum disease.	For non-responding sites after periodontal therapy; limited to one service per tooth with a maximum of two teeth in a 24-month period

High-Cost Restorations (Restorations) Note: The procedures in this category should be reviewed by us before they're performed. To learn more, see the Pre-Treatment Plan Estimate section.		
Benefit	Description	Limit (if any)
Restorations for complicated tooth decay or fracture	Restoring a tooth with a different type of filling (i.e. cast) when the tooth cannot be restored with a silver (amalgam) or tooth-colored (composite) filling.	This procedure is a benefit once every (5) five years, beginning from the date the restoration is cemented in place.
Crowns	Restoring form and function by covering and replacing the visible part of the tooth with a precious metal, porcelain fused to metal or a porcelain crown.	Crowns are a benefit only if the tooth can't be restored with a routine filling; Crowns are a benefit once every (5) five years, beginning from the date the restoration is cemented in place. Crowns placed mainly for 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.
Inlays	an intra-coronal dental restoration made outside the oral cavity and does not restore any cusp tips.	Benefit is limited to the amount paid for a silver (amalgam) filling; This procedure is a benefit once every (5) five years, beginning from the date the cast restoration is cemented in place.
Onlays	a restoration made outside the oral cavity that covers one or more cusp tips, but not the whole external surface.	This procedure is a benefit once every (5) five years, beginning from the date the restoration is cemented in place.
Posts and cores	Preparing a tooth for a crown after a root canal to strengthen the tooth.	This procedure is a benefit once every (5) five years, beginning from the date the restoration is completed.
Recementation of Restorations	Recementation of an inlay, onlay, or crown that has become loose.	This procedure is a benefit once every 12 months—after (6) six months have elapsed since initial placement.

Dentures and Bridges (Prosthetics) Note: The procedures in this category should be reviewed by us before they're performed. To learn more, see the Pre-Treatment Plan Estimate section.		
Benefit	Description	Limit (if any)
Bridges	Replacing missing permanent teeth with a dental prosthesis that is cemented in place and can only be removed by a dentist; bridge repairs are also covered.	This procedure is a benefit once every (5) five years. 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 removable dental prosthesis; denture repair and relining are also covered	This procedure is a benefit once every (5) five years.
Denture Adjustments	Adjustments made to the dentures to ensure proper fit or restore function, comfort or to fit.	This benefit is limited to two per denture per Benefit Period—after (6) six months have elapsed since initial placement.
Tissue conditioning	Improves the health of gum tissues under a denture.	This benefit is limited to two per denture every 36 months.

Dental Implants (Prosthetics) Note: The procedures in this category should be reviewed by us before they're performed. To learn more, see the Pre-Treatment Plan Estimate section.		
Dental Implants	Implants that are surgically placed in the jawbone, including attachment of devices to a surgically placed implant in the jaw.	This procedure is a benefit once every (5) five years.

Services Not Covered (Certificate Exclusions)

This Certificate does not provide benefits for the treatment, service or supplies in this section. Just because a treatment, service, or supplies aren't specifically listed here doesn't mean it's covered. If you're not sure if something is covered, call us at the number provided on the back cover of this Certificate. We're happy to help.

Treatment, Service or Supplies:	What's NOT covered (Excluded) - You are not covered for:
Anesthesia or analgesia	You are not covered for general anesthesia, intravenous sedation, local anesthesia, non-intravenous conscious sedation or nitrous oxide (relative analgesia).
Broken appointments	Fees charged by your dental office because of broken appointments.
Certificate Termination	Whether we have approved a treatment plan or not, you are not covered for treatment received after the coverage termination date of this Certificate.
Complete occlusal adjustment	Services or supplies used to revise or alter the functional relationships between upper and lower teeth.
Complications of a non-covered procedure	Costs related to dental problems that result from a non-covered procedure.
Congenital deformities	Services or supplies to fix congenital deformities, such as cleft palate.
Cosmetic in nature	Services or supplies that are mainly to improve the appearance of your teeth rather than restoring or improving dental form and function of natural teeth.
Desensitizing medicament or resin	The application of desensitizing medicament or resin for cervical and/or root surface sensitivity either on a per tooth or per visit basis.
Drugs	Prescription or non-prescription drugs or medications.
Effective date	Services or supplies received before the Contract Period Effective Date of coverage under this Certificate.
Experimental or Investigative	Services or supplies that are considered experimental, investigative or have a poor prognosis. We will use Peer-reviewed outcomes data from clinical trials, Food and Drug Administration regulatory status, and established governmental and professional guidelines to make this determination.
Extraoral x-rays	You are not covered for Extraoral x-rays.
Government programs	Services or supplies when you're entitled to benefits from government programs (except Medicaid and CHIP).
Incomplete services	Dental services that haven't been completed.
Indirect pulp caps	Indirect pulp caps are not covered.

Infection control	Separate charges for "infection control." This includes the costs for services and supplies for sterilization procedures and personal protective equipment. Delta Dental Dentists include these costs into their normal fees.
Lost or stolen appliances	Services or supplies to replace lost or stolen dental appliances.
Medical services or supplies	Services or supplies that are medical in nature, including, but not limited to: Dental services performed in a hospital Treatment of fractures and dislocations Treatment of cysts and malignancies Accidental injuries
Military service	Services or supplies needed to treat an illness or injury received while you're on active status in the military services. However, if you ask in writing, you may get a refund of premiums you paid while on active military status.
Payment responsibility	Services or supplies when: Someone else has the legal obligation to pay for your care; and, When you wouldn't be charged if you did not have this Certificate.
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	Services or supplies used mainly for reducing tooth mobility, including crown-type restorations.
Plaque-control programs, oral hygiene instructions and dietary instructions	Services or supplies for plaque control, oral hygiene and/or dietary instructions are not covered.
Provisional crowns, bridges or dentures	Services or supplies for provisional crowns, bridges or dentures are not covered.
Repair, replacement or duplication of orthodontic appliances	Services or supplies needed to fix, replace or duplicate any orthodontic appliance are not covered.
Sales tax and fees	We do not pay sales tax or fees billed by dentists for dental services.
Services not paid to some extent by us	Services that would otherwise qualify as a Covered Service, but Delta Dental does not make a payment to some extent. This may include services not paid because of your need to satisfy applicable Waiting Periods, Deductibles, copayments, Member Coinsurance, Benefit Period Maximums, and/or frequency limitations.
Services not provided in a dental office setting	Services not provided in a dental office setting. Exceptions may be made for care provided by teledentistry, in a mobile dental unit, hospital setting,

	or long term care facility.
Specialized services	Specialized, personalized, elective materials and techniques or technology that aren't reasonably needed for the diagnosis or treatment of dental disease or dysfunction. Specialized services are enhancements to other services and are considered optional.
Straighter teeth - Corrective orthodontics	You are not covered for Corrective Orthodontics. Corrective Orthodontic services are orthodontic procedures, that move teeth to correct an abnormal dental relationship between and among teeth.
Temporary or interim procedures	Temporary or interim procedures are not covered.
Temporomandibular joint dysfunction (TMD)	Costs for diagnostic x-rays, appliances, restorations or surgery for TMD or myofunctional therapy are not covered.
Treatment by a non-licensed dentist or non-licensed physician	Services or treatment performed by anyone but a licensed dentist, licensed physician, or their employees. Covered Services provided in states where other types of dental providers can practice independently are allowed.
Treatment in Progress	You may not be covered for services or supplies related to treatment which began prior to the effective date of this Certificate.
Unerupted teeth	Prophylactic removal of unerupted teeth (asymptomatic and nonpathological). Meaning, the removal of any unerupted tooth that aren't visible or isn't causing harm is not covered.
Workers' compensation	Services or supplies that are or could have been paid under a Worker's Compensation laws, including those applied toward any Deductible under your employer's Worker's Compensation coverage.

Pre-Treatment Plan Estimate Process

When you need any kind of dental care, it's a good idea to make sure you, your dentist and your insurance company are on the same page. That's what the Pre-Treatment Plan Estimate does for you. The purpose of Pre-Treatment Plan Estimate is to help control the cost of your benefits — not to keep you from receiving dentally necessary and dentally appropriate treatment. Our benefit review is based on the treatment plan submitted by your dentist. Think of it as a system of checks and balances for your dental coverage. The Pre-Treatment Plan Estimate helps:

- Determine whether services are dentally necessary and dentally appropriate;
- Confirm the benefits of your Certificate; and
- You understand your payment and ours, if covered.

What you should do

For certain dental care, you should notify us before treatment starts. For others, you must notify us and get our approval first.

You should notify us before you get services for the following benefit categories:

- Periodontal surgery
- High-cost restorations (including crowns, onlays and bridges)
- Dental implants
- Any treatment that will cost more than $300

What's a treatment plan?

Your dentist creates the treatment plan. It describes the treatment he or she recommends for you. It also helps us determine if the procedure is a benefit under your Certificate and if it is dentally necessary and dentally appropriate.

Who sends the treatment plan to us?

As long as your dentist is a Delta Dental Participating Dentist, he or she will send the treatment plan to us. (That's another benefit of working with an in-network dentist!)

But, if your dentist is a Non-Participating Dentist, you'll need to send the treatment plan to us. A complete treatment plan includes:

- The plan of treatment, and
- X-rays (please send x-rays within 15 business days of receipt of the proposed treatment plan)

Where to send a treatment plan

If your dentist is a Non-Participating Dentist, you'll need to send the proposed treatment plan, x-rays and supporting information to:
Delta Dental of Iowa
P.O. Box 9000
Johnston, IA 50131-9000

Our review of the treatment plan

Once we get your treatment plan and related information, we'll review everything. Then we'll let you and your dentist know of our decision within 15 business days of receiving the

information.

We'll either:

- Accept the treatment plan.
- Recommend an alternative benefit. If we ask you to receive a second opinion from a dentist of our choice we'll pay for the exam.
- Deny the treatment plan because:
    - The procedure isn't a benefit of your Certificate;
    - You didn't get a second opinion after we asked you to; or
    - The procedure isn't dentally necessary and dentally appropriate.

What you can do if the treatment plan is denied

If we deny a treatment plan, you can ask us to reconsider. To do that, resubmit the plan with more information and ask us—in writing—to reconsider. If needed, we may have you get an exam from an independent dentist of our choice – we'll pay for the exam.

Keep in mind, even if we approve a treatment plan, we're not liable for the actual treatment you get from your dentist.

Filing claims

Once you get dental care, we need to receive a claim. The claim lets us know what services you got, as well as when and from whom.

If your dentist is a Delta Dental Participating PPO or Premier Dentist, he or she will file the claim for you. (Another advantage of seeing in-network dentists.)

If you see a Non-Participating Dentist, though, you may need to file the claim yourself.

When to file a claim

You should only file a claim if your dentist hasn't filed one for you — and only *after* the procedure is finished.

Make sure the claim is filed promptly after the procedure is done. We may not pay a claim submitted more than 365 days after the services were provided.

If you need a claim form or have questions, please call us at 800-544-0718 or visit www.deltadentalia.com.

If you need to file your own claim, send it to:

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

Filing claims when you have more than one plan or other coverage.

Coordination of Benefits

You may have other dental coverage that provides the same or similar benefits as this

Certificate. If so, we'll work with your other insurance company to coordinate benefits. The benefits payable under both policies will not be more than 100 percent of either insurance carrier's payment arrangement amount.

When you get dental care, you need to let us know that you have other coverage. Other coverage includes:

- Group insurance (like employer-sponsored)
- Other group benefit plans (such as HMOs, PPOs and self-insured programs)
- Individual and Family dental insurance
- Medicare or other governmental benefits
- Medical benefits coverage under your auto insurance

What you should do

To help us coordinate your benefits, you should:

- Tell your dentist about your other coverage when you get 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. We'll let you know if we need any additional information.
- Let us know if you lose your other coverage or it changes.

You must cooperate with us and provide requested information about your other dental coverage. If you don't, your claims will be denied.

What we'll do

We'll coordinate the benefit payments between your policies. To do this, we need to determine the order in which each plan will pay. In other words, which plan pays first, and which pays second and so on. Below are the guidelines that help us determine the payment order when you have more than one plan.

If…	Then…
Both coverages are through a group sponsor (like an employer), but one coverage has coordination of benefits and one doesn't.	The coverage without coordination of benefits pays first.
Coverage is through an auto policy, and it doesn't have a coordination of benefits provision.	The dental benefits of your auto coverage will pay before this Certificate.
Coverage held as an employee or policyholder (i.e. Individual & Family policy).	It pays before the coverage you have as a Spouse or Child.
Coverage is held as an active employee.	It pays before coverage you hold as a retiree or under which you're not actively employed.
None of the above guidelines apply.	The coverage with the earliest continuous effective date pays first.

If none of the guidelines or situations above apply, we'll rely on the coordination of benefits (COB) rules provided in the Iowa Administrative Code to determine the order of payment between the polices and our payment to you or your dentist.

How we coordinate benefits for Children

Here are the guidelines we follow to coordinate benefits for your Children when they are covered by more than one dental plan.

If the Child is…	Then…
Covered by both parents who aren't separated or divorced.	The coverage of the parent whose birthday occurs first in a calendar year pays first. If the other carrier doesn't use this guideline, then the other plan will pay first.
Covered by both parents who are separated or divorced but neither parent has primary physical custody.	The coverage of the parent whose birthday occurs first in a calendar year pays first. If the other carrier doesn't use this guideline, then the other plan will pay first.
Covered by separated or divorced parents and a court decree says which parent has financial or dental insurance responsibility.	That parent's plan pays first.
Covered by separated or divorced parents and a court decree does *not* say which parent has financial or dental insurance responsibility.	The coverage of the parent with custody pays first. The payment order for this Child is: • Custodial parent • Spouse of custodial parent • Other parent • Spouse of other parent
None of the guidelines above apply.	The parent's coverage with the earliest continuous effective date pays first.

If none of the guidelines or situations above apply, we'll rely on the coordination of benefits (COB) rules provided in the Iowa Administrative Code to determine the order of payment between the polices and our payment to you or your dentist.

Appealing our claims decision

If we don't pay all or part of your claim and you think we should, you or your personal representative have the right to ask for an appeal. An appeal is a full and fair review of a claim that we didn't pay in full or in part (adverse benefit determination), without considering our initial decision. To request an appeal, submit a written request within 180 days of receiving the notice letter or explanation of benefits for the claim from us. The written request for an appeal must include:

- The reason why you disagree with our claim decision;
- Documents, records and any other information related to the claim; and,
- Your name, the patient's name and address and identification number on all documents

Our reply
Generally, within 30 days of receiving your request, we'll send you our decision in writing. We'll also tell you about any action we have taken. During this time, you may send us additional documentation to support the claim.

Sometimes we may need 60 days. If that happens, we'll let you know in writing. After that time, we'll make the final decision on the claim based on the information we have in our file.

Reviewing records
When you ask us, we'll give you access to and copies of all documents, records, and other information related to your claims for benefits. There's no cost for this.

To schedule an appointment, just call us in advance at 800-544-0718 or mail your request to:
Delta Dental of Iowa
P.O. Box 9010
Johnston, IA 50131-9010

You can review these records at our office Monday through Friday, from 8:00 a.m. to 4:30 p.m. Central Standard Time. Your records are also available online via our secure member website. To access your records online go to www.deltadentalia.com and set up an account.

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 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 have furnished you with a copy of the statement.

Eligibility enrollment requirements

To be eligible for this Certificate:

- 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 and qualifying events

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

- Active duty in the military of an eligible child or spouse
- Appointment as a legal guardian of a child
- Birth or adoption of a child
- Care of a foster child (when placed in your home by an 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 or child loses eligibility for qualifying dental coverage, i.e., employer or group sponsor stops contributing to qualifying dental plan. In this case, your spouse or child would be eligible for coverage under this Certificate.
- Spouse's or Child's Medicaid, or Children's Health Insurance Program (CHIP) (i.e. Healthy and Well Kids in Iowa "Hawki") coverage is terminated as a result of losing eligibility or the Covered Person becomes eligible for a premium assistance subsidy under Medicaid or CHIP. You need to request coverage within 60 days of losing coverage or 60 days from when eligibility for premium assistance is determined.

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 will also 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.

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 for Medicaid, CHIP, or Hawki. You can ask your employer or group sponsor to help you make this request. If a change to your eligibility isn't made within 31 days of the event, the person(s) affected may lose coverage. Upon notification of a member's death, we will only return premiums for a period of up to 18 months following the date of death.

Please note: You must notify us when there is a change in your marital status (i.e. divorce or legal separation) or a Child loses eligibility status.

Authorized Certificate changes

No agent, employee, or representative of ours is authorized to change or waive any of the provisions of this Certificate. This Certificate may only be changed when we:

- Need to make changes to comply with federal or state laws. When this happens, we'll automatically amend this Certificate to comply.
- Send you a 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.
- Receive proper notice that your marital or eligibility status has changed.

When coverage begins

Your coverage under this Certificate starts on your Contract Period Effective Date. If you have just started a new job, check with your employer or group sponsor to find out your effective date. Before you receive benefits under this Certificate, you must allow any healthcare provider to give us information about a treatment or condition for which we are being billed. If we don't get the information requested (or if you withhold information in your application), you may not get coverage and benefits may be denied.

If you give us false or misleading information, conceal important details in your application or use the benefits in this Certificate in a fraudulent manner, we may end (terminate) your benefits.

When coverage ends

Your coverage will end (terminate) on the last day of the month following any of these events.

- You become ineligible for coverage under this Certificate.
- 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 end coverage of all similar policies by giving your employer or group sponsor written notice at least 90 days before it will end.

Your coverage will end (terminate) if any of the following happens:

- You use this Certificate fraudulently. Note: We may recover any claims payments we made, minus any premiums you paid.
- You fraudulently misrepresent or hide important facts in your application. Note: We'll recover any claim payments we made, minus any premiums you paid.

- You or your employer or group sponsor don't pay your premium when it's 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 immediately. 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 Child(ren) 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 Child(ren) 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 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 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 of 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.

Effects of termination

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

- We won't pay for any services or supplies provided after the date the coverage is terminated.
- We'll keep legal rights—including the right to initiate a civil action.
- We may declare the coverage void.

If your coverage is terminated for reasons other than fraud, concealment or misrepresentation of material facts, we'll 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 due to an illness or injury, we'll assume any legal right you have to collect any payment related to the illness or injury. That includes benefits from:

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

You agree to all of the following: That you will:

- Let us know about any potential claims or rights of recovery related to the illness or injury.
- Give us any information or help we need to enforce our rights under this Certificate.
- Not do anything to prejudice our rights and interests.
- Not compromise, settle, surrender or release any claim or right of recovery described

above without our written permission.
- Reimburse us for benefit payments made under this Certificate, if you get paid from the other party.
- Let us know if you may have the right to receive payment from someone else.
- Cooperate with us to make sure our rights to subrogation are protected.

Other information notice

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

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

Any notice from us to you is valid when sent to the address we have for you in our records or the address of the group through which you are enrolled.

Nonassignment
Benefits in this Certificate are for you. They can't be transferred or assigned to anyone else without our written permission.

Governing law
This Certificate will be interpreted in accordance with and governed by the laws of the state of Iowa, unless any federal laws supersede state laws. 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.

For people enrolled in Medicaid
This Certificate will pay benefits for Covered Services to you, or any other person who has been legally assigned the right to receive such benefits under Title XIX of the Social Security Act (Medicaid).

Enrollment without regard to Medicaid or CHIP
Your receipt or eligibility for medical assistance under Title XIX of the Social Security Act (Medicaid or CHIP) will not affect your enrollment as a Covered Person(s) under this Certificate. It also won't affect our determination of any benefits paid to you.

Third-Party liability for Medicaid payments
If payment has been made by Medicaid, and we have a legal obligation to provide benefits for those services, we'll pay those benefits in accordance with the terms of this Certificate and any state law under which a state acquires the right to such payments.

Payer of Last Resort
If you are covered by this Certificate and one or more Government-sponsored healthcare or

dental programs, such as Medicaid (DWP) or CHIP (Hawki) during the same Benefit Period as this Certificate, federal and state law requires this Certificate to provide benefits first (or as primary) and the Government-sponsored healthcare/dental programs to provide benefits second (or secondary). If you have coverage from all three of these types of policies at the same time (which is rare, but sometimes happens); the order of benefit processing and payments will be this Certificate, then Hawki and then Medicaid.

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. In addition, if you disagree with the plan's decision or lack

thereof concerning the qualified state of a domestic relations order or medical child support order, you may file suit in 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 complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. To review our full nondiscrimination notice go to www.deltadentalia.com/nondiscrimination.

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