



BENEFITS CERTIFICATE

ISU Dental Plan Comprehensive Option and Basic Option

DELTA DENTAL OF IOWA

Effective Date: 02/01/2006
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Form Number: DDCERT0302

I NTERPRETING THIS CERTIFICATE

It is important that you understand all parts of this 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 family members eligible 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.

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 - Comprehensive Option	5
Summary of Benefits and Payment - Basic Option	7
Important Information	9
What You Should Know About Delta Dental Dentists	9
What You Should Know About Dentists Who Do Not Participate With Delta Dental	10
Questions We Ask When You Receive Dental Care	10
Our Payment Policy	11
How Waiting Periods Affect Benefit Payment	12
Understanding Payment Vocabulary	12
Understanding Amounts You Pay To Share Costs	13
Helping When You Have Questions	14
Benefits	15
Check-Ups And Teeth Cleaning	15
Cavity Repair And Tooth Extractions	16
Root Canals	17
Gum And Bone Diseases	18
High Cost Restorations	19
Dentures And Bridges	20
Straighter Teeth	21
Services Not Covered	22
The Notification Program	27
The Approval	27
The Treatment Plan	27
The Treatment Plan Review	28

Filing Claims 29

 When To File Your Claim 29

 Filing When You Have Other Coverage 29

 Appealing A Denied Claim 31

Your Certificate 33

 Coverage Eligibility 33

 Eligible Requirements 33

 When Coverage Begins 34

 Types of Coverage 35

 Qualified Medical Child Support Order (QMCSO) 36

 When Coverage Ends 38

 Continued Coverage (COBRA) 40

 Coverage Changes 42

 Events Changing Coverage 42

 Notification Of Change 43

 Authorized Certificate Changes 43

 Coverage Termination 43

 Effects Of Termination 43

 Our Right To Recover Payments 44

 Payment In Error 44

 Subrogation 44

 Other Information 45

 Summary Plan Description 47

SUMMARY OF BENEFITS AND PAYMENT

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

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

COMPREHENSIVE OPTION	DEDUCTIBLE	COINSURANCE	BENEFIT PERIOD MAX	LIFETIME MAX
Benefit Categories	\$25 per family per benefit period		\$1,500	\$2,000
Check-Ups and Teeth Cleaning (Diagnostic and Preventive Services) 1. Dental Cleaning 2. Oral Evaluation 3. Fluoride Applications 4. X-rays 5. Sealant Applications 6. Space Maintainers 7. Bacteriologic Cultures 8. Histopathologic Exams 9. Diagnostic Casts 10. Emergency Treatment 11. Biopsy of Oral Tissue 12. Pulp Vitality	Waived	00%	Yes	
Cavity Repair and Tooth Extractions (Routine and Restorative Services) 1. General Anesthesia/Sedation 2. Restoration of Decayed or Fractured Teeth 3. Limited Occlusal Adjustment 4. Routine Oral Surgery	Yes	20%	Yes	

COMPREHENSIVE OPTION	DEDUCTIBLE	COINSURANCE	BENEFIT PERIOD MAX	LIFETIME MAX
Cavity Repair and Tooth Extractions (continued) (Routine and Restorative Services) 5. Space Maint. Recementing 6. Repositioning of Teeth 7. Antibiotic Drug Injection 8. Consultations	Yes	20%	Yes	
Root Canals (Endodontic Services) 1. Apicoectomy 2. Direct Pulp Cap 3. Pulpotomy 4. Retrograde Fillings 5. Root Canal Therapy	Yes	20%	Yes	
Gum and Bone Diseases (Periodontal Services) 1. Conservative Procedures 2. Complex Procedures 3. Maintenance Therapy 4. Periodontal Appliance	Yes	20%	Yes	
High Cost Restorations (Cast Restorations) 1. Cast Restorations a. Crowns b. Inlays c. Onlays d. Posts and Cores	Yes	50%	Yes	
Dentures and Bridges (Prosthetics) 1. Bridges 2. Dentures 3. Bridge Repair and Recementing 4. Denture Relining 5. Denture Repair and Recementing	Yes	50%	Yes	
Straighter Teeth (Orthodontics)	\$50 per person in a lifetime	50%		Yes

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

BASIC OPTION	DEDUCTIBLE	COINSURANCE	BENEFIT PERIOD MAXIMUM
Benefit Categories	\$0		\$750
Check-Ups and Teeth Cleaning (Diagnostic and Preventive Services) <ol style="list-style-type: none"> 1. Dental Cleaning 2. Oral Evaluation 3. Fluoride Applications 4. X-rays 5. Sealant Applications 6. Space Maintainers 7. Bacteriologic Cultures 8. Histopathologic Exams 9. Diagnostic Casts 10. Emergency Treatment 11. Biopsy of Oral Tissue 12. Pulp Vitality 		0%	Yes
Cavity Repair and Tooth Extractions (Routine and Restorative Services) <ol style="list-style-type: none"> 1. General Anesthesia/Sedation 2. Restoration of Decayed or Fractured Teeth 3. Limited Occlusal Adjustment 4. Routine Oral Surgery 		50%	Yes

BASIC OPTION	DEDUCTIBLE	COINSURANCE	BENEFIT PERIOD MAXIMUM
<p>Cavity Repair and Tooth Extractions (continued) (Routine and Restorative Services)</p> <ul style="list-style-type: none"> 5. Space Maint. Recementing 6. Repositioning of Teeth 7. Antibiotic Drug Injection 8. Consultations 		50%	Yes
<p>Root Canals (Endodontic Services)</p> <ul style="list-style-type: none"> 1. Apicoectomy 2. Direct Pulp Cap 3. Pulpotomy 4. Retrograde Fillings 5. Root Canal Therapy 		50%	Yes
<p>Gum and Bone Diseases (Periodontal Services)</p> <ul style="list-style-type: none"> 1. Conservative Procedures 2. Complex Procedures 3. Maintenance Therapy 4. Periodontal Appliance 		50%	Yes
<p>High Cost Restorations (Cast Restorations)</p> <ul style="list-style-type: none"> 1. Cast Restorations <ul style="list-style-type: none"> a. Crowns b. Inlays c. Onlays d. Posts and Cores 		50%	Yes
<p>Dentures and Bridges (Prosthetics)</p> <ul style="list-style-type: none"> 1. Bridge Repair and Recementing 2. Denture Relining 3. Denture Repair and Recementing 		50%	Yes

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

- Delta Dental dentists agree to accept Delta Dental'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.

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

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

- We do not have contracting relationships with nonparticipating dentists and they do not agree to accept Delta Dental’s payment arrangements. This means you are responsible for any difference between your nonparticipating dentist’s covered charge and the Maximum Plan Allowance (Delta 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.
- 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”).

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

Is the Procedure Dentally Appropriate?

All of the following must be true for a procedure to be considered dentally appropriate:

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

Is the Procedure Subject to Contract Limitations?

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

- Amounts for procedures that are not dentally necessary or dentally appropriate.
- Amounts for procedures that are not covered by this certificate. See SERVICES NOT COVERED.
- Amounts for procedures that have limitations associated with them. For example, 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 covered charge and the Maximum Plan Allowance (Delta Allowance). **Please note:** This only applies if you receive services from a nonparticipating dentist.

OUR PAYMENT POLICY

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

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

HOW WAITING PERIODS AFFECT BENEFIT PAYMENTS

A waiting period is the amount of time you and your family member(s) must wait before certain benefits are available under this certificate. Waiting periods do not apply to accident care.

Waiting periods do apply when:

- you initially decline coverage for yourself or your family members and later enroll.

If waiting periods apply to you, then you, the member requiring dental services, must be covered by this certificate for 12 consecutive months before benefits are available in the following benefit categories:

Cavity Repair and Tooth Extractions

Root Canals

Gum and Bone Diseases

High Cost Restorations

Dentures and Bridges

This waiting period may be removed before it would otherwise expire if proof of your good dental health is submitted to and approved by Delta Dental. They will determine the type and form of required proof. You must pay the cost of obtaining that proof.

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 benefit of your certificate*.

Maximum Plan Allowance (Delta Allowance)

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

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

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

UNDERSTANDING AMOUNTS YOU PAY TO SHARE COSTS

Deductible

Deductible is the fixed dollar amount you pay for covered services 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 members.

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 (Delta 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 member 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.

Services received from BENEFIT CATEGORY: STRAIGHTER TEETH are excluded from your benefit period maximum.

Lifetime Maximum

In a member's lifetime, total benefits are limited by dollar amount for BENEFIT CATEGORY: STRAIGHTER TEETH. This amount is shown on the SUMMARY OF BENEFITS AND PAYMENT chart at the beginning of this certificate.

HELPING WHEN YOU HAVE QUESTIONS

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

BENEFITS

CHECK-UPS AND TEETH CLEANING DIAGNOSTIC AND PREVENTIVE SERVICES

Dental Cleaning (Prophylaxis)

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

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

Oral Evaluations

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

Topical Fluoride Applications

Limitation: Topical fluoride is a benefit only once every 12 consecutive months.

X-Rays:

Bitewing X-Rays

Limitation: These x-rays are a benefit only 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.

Extraoral X-Rays

Limitation: These x-rays are a benefit only once every 6 consecutive months.

Periapical X-Rays

Occlusal X-Rays

Cephalometric X-Rays

Limitation: These x-rays are a benefit only once every 6 consecutive months.

Bacteriologic Cultures, Histopathologic Exams, Pulp Vitality Tests, Diagnostic Casts

Limitation: Bacteriologic Cultures, histopathologic exams, pulp vitality tests and diagnostic casts are a benefit only once every two consecutive years.

Sealant Applications

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

Limitation: Sealant applications are a benefit:

once per permanent first and second molars for eligible dependent children under age 15.

Sealants 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 dependent children under age 14.

Emergency Treatment (Palliative Treatment)

Treatment to relieve pain or infection of dental origin.

CAVITY REPAIR AND TOOTH EXTRACTIONS ROUTINE AND RESTORATIVE SERVICES

General Anesthesia/Sedation

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

Restoration of Decayed or Fractured Teeth

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

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

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.

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

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.

Antibiotic Drug Injections

Consultations

Consultations between two dentists about your course of treatment.

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. *Treatment of pulp that is not exposed (indirect pulp cap) is not a benefit.*

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: Procedures in this category should receive our review *before* they are performed. See THE NOTIFICATION PROGRAM.

Full Mouth Debridement

Limitation: Full mouth debridement is a benefit once in a lifetime.

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 24 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 must 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.*

HIGH COST RESTORATIONS CAST RESTORATIONS

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 and abrasion are not a benefit. Limitation:* Crowns are a benefit only if the tooth cannot be restored with a routine filling.

Inlays

Restoring a tooth with a cast metallic or porcelain filling.

Limitation: **Inlay benefits are limited to the amount paid for a silver (amalgam) filling.** See *Restoration of Decayed or Fractured Teeth*, described under Cavity Repair and Tooth Extractions earlier in this section.

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 (COMPREHENSIVE OPTION) PROSTHETICS

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

Bridges

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

Dentures (Complete and Partial)

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

Limitation: Relining is available only if performed one year or more after the initial placement of the denture and then once every two years thereafter.

Implants

Dental implants which are surgically placed in the jaw bone, including attachment of devices to a surgically placed implant in the jaw.

Denture Adjustments

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

Tissue Conditioning

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

DENTURES AND BRIDGES (BASIC OPTION) PROSTHETICS

REPAIRS

Repairing a dental prosthesis including bridges, or full or partial dentures is covered. Also covered is adding a tooth to an existing partial denture.

DENTURE RELINING

Limitation: Relining is available only if performed one year or more after the initial placement of the denture and then once every two years thereafter.

STRAIGHTER TEETH (COMPREHENSIVE OPTION)

ORTHODONTICS

Orthodontics. Services for proper alignment of teeth.

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

If orthodontic treatment is stopped for any reason before it is completed, Delta Dental of Iowa will pay only for covered services and supplies actually received.

No benefits are available for charges made after treatment stops or after the termination of coverage.

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

S ERVICES 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. This exclusion does not apply to general anesthesia or intravenous sedation administered in connection with covered oral surgery as described in BENEFITS.

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. However, you are covered for limited occlusal adjustment, a less complex procedure to reshape the biting surfaces of one or more teeth.

Complications of a Non-Covered Procedure

You are not covered for complications of a non-covered procedure.

Congenital Deformities

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

Controlled Release Device

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

Cosmetic in Nature

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

Crowns Not Meant to Restore Form and Function

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

Desensitization Material

You are not covered for desensitization materials or their application.

Drugs

You are not covered for prescription, non-prescription drugs, 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).

Guided Tissue Regeneration

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

Implants (BASIC OPTION)

You are not covered for any dental implants which are surgically placed in the jawbone. You are also not covered for the attachment of any device to a surgically placed implant in the jawbone.

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 (Basic Option)

You are not covered for orthodontics under the Basic Option.

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.

Prosthetics (Basic Option)

You are not covered for prosthetics, including bridges and dentures. This exclusion does not include repairs or relining as described in BENEFITS for the Basic Option.

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.

Sealants for Primary Teeth, Wisdom Teeth, or Restored Teeth

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

Services Provided in Other Than Office Setting

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

Specialized Services

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

Temporary or Interim Procedures

You are not covered for temporary or interim procedures.

Temporomandibular Joint Dysfunction (TMD)

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

Treatment By Other Than A Licensed Dentist

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

Unerupted Teeth

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

Workers' Compensation

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

THE NOTIFICATION PROGRAM

This section explains the notification program you or your Delta Dental dentist should follow before you receive certain benefits available under this certificate.

This program is the checks and balances of your dental coverage. It helps:

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

THE APPROVAL

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

You should notify us before you receive the following benefits:

Gum and Bone Diseases

You should also notify us before you receive treatment from any benefit category that will exceed \$200.

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 919
Ankeny, IA 50021-0919*

THE TREATMENT PLAN REVIEW

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

- *accept* it as submitted.
- *recommend an alternative benefit*. If we ask you to receive an independent diagnosis from a dentist of our choice, we will pay for the exam.
- *deny the treatment plan* because:
 - the procedure is not a benefit of your 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. We must receive all claims within 365 days after the end of the year you receive services.

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. For your convenience, we have listed our toll-free number on the back cover of this certificate. If you must file your own claim, send it to the following address:

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

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 plan member* pays before the coverage which you have as a spouse or dependent child.
- The coverage you have as *the result of your active employment* pays before coverage you hold as a retiree or under which you are not actively employed.
- The coverage with the *earliest continuous effective date* pays first when none of the above rules apply.

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

What You Should Know About Dependent Children

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

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

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

APPEALING A DENIED CLAIM YOUR INITIAL REQUEST FOR A REVIEW

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

ADDITIONAL INFORMATION

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

DELTA DENTAL'S REPLY

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

REVIEWING RECORDS

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

Send your request to:

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

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 benefits certificate, and any riders or amendments. All of the statements made by you or ISU in any of these materials will be treated by us as representations, not warranties. We will not use the statements to deny any claim unless we've furnished you with a copy of the statement.

COVERAGE ELIGIBILITY ELIGIBLE REQUIREMENTS

Each employee who began work before the effective date of this contract is eligible to enroll for benefits on the effective date of this contract. If an employee does not enroll at the time of the original enrollment of the group, the employee is eligible to apply *with waiting periods*.

New employees are eligible to apply for coverage:

- within 31 calendar days following the date of employment; or
- with waiting periods.

Please note: An employee means any person classified as Professional, Scientific, Faculty, or Supervisory Merit System employee, who is a regular budgeted employee of the University for at least 1/3 time or more for nine months or longer.

Retired employees are also eligible for coverage.

Please note: A retired employee means any person who, prior to retirement, was classified as Professional, Scientific, Faculty, or Supervisory Merit System employee, and who was a regular budgeted employee of the University for at least 1/3 time or more for nine months or longer. Retiree must have 5 years of continuous dental coverage immediately prior to retirement

Also, if such person retired prior to July 1, 1990, he or she must have elected to continue dental coverage during the open enrollment period of June 11, 1990, through July 31, 1990, or December 1996.

You will be eligible on the date you retire.

WHEN COVERAGE BEGINS

Your coverage will normally be in force on:

- the date you are eligible, if that date is the first day of the calendar month provided you complete enrollment within 31 days of eligibility.

However, if you are not actively at work on the date coverage would otherwise be effective, your coverage will not be in force until the day you return to active work.

Coverage for your dependents will be in force under the same terms except:

- coverage will not be effective unless you are covered for employee coverage; and
- a dependent acquired after your dependent coverage is already in force will be covered on the date acquired.

In addition, if you make your request more than 31 days after the date you are eligible, you or your dependent dental coverage will be subject to waiting periods as described in the **IMPORTANT INFORMATION** section of this certificate.

Please note: Before you receive benefits under this certificate, you have agreed in your application for coverage (or in documents kept by ISU or Delta Dental) to release any necessary information requested about you so Delta can process claims for benefits. You must allow any dentist or his or her employee to give Delta information about a treatment or condition. If Delta does not receive the information requested, or if you withhold information in your application, your benefits may be denied.

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

TYPES OF COVERAGE

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

Active Employees:

- With *single coverage*, the plan member is the only one covered.
- With *employee and spouse coverage*, the plan member and his or her spouse or domestic partner are covered.
- With *employee and child(ren) coverage*, the plan member and his or her eligible, dependent child(ren) are covered.
- With *family coverage*, the plan member, his or her spouse or domestic partner, and each of his or her eligible dependent children have coverage. Each covered family member must be listed on the plan member's dental application or added later as a new member.

Please note: A husband and wife who are both employees (double spouse), may not be covered as both "employees" and "dependents" under the plan. One must choose to be the "employee" and the other will then be the "dependent" of that "employee" under the plan. A husband and wife may elect to change their classifications so that the husband is the "employee" and the wife is the "dependent" or vice versa, during a calendar year. Employees changing their types of coverage from "dependents" to "employees" or vice versa, will have deductible and out-of-pocket credits transferred as well.

Retired Employees:

- With *single coverage*, the plan member is the only one covered.
- With *retiree and spouse coverage*, the plan member and his or her spouse or domestic partner are covered.
- With *retiree and child(ren) coverage*, the plan member and his or her eligible, dependent child(ren) are covered.
- With *family coverage*, the plan member, his or her spouse or domestic partner, and each of his or her eligible, dependent children have coverage. Each covered family member must be listed on the plan member's dental application or added later as a new member.

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

- The child is *not married* and either under 19 years of age or a full-time student; or

- The child is totally and permanently disabled, either physically or mentally according to IRS guidelines. The dependent child must be covered as a dependent at the time of disability under an Iowa State University dental plan.

A dependent child who has been placed in your home for the purpose of adoption or who you have adopted shall be eligible for coverage as of the date of placement for adoption or as of the date of actual adoption, whichever occurs first.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

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

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

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

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

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

Once your employer decides that a court order is a Qualified Medical Child Support Order, the order is binding on both the employer and us, meaning that the dependent is eligible to enroll under the applicable terms and conditions of the plan

as well as our standard enrollment guidelines. Your employer must allow enrollment of the dependent regardless of any enrollment season restrictions that normally apply. Also, your employer must forward a copy of the order to us and ask that we enroll the dependent in the plan.

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

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

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

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

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

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

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

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

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

- The court or administrative order requiring coverage in a benefit plan is no longer in effect.
- The dependent's eligibility for or enrollment in a comparable benefit plan that takes effect on or before the date the dependent's enrollment in this plan terminates.
- The employer's elimination of dependent coverage for all employees.

Your employer is not required to maintain coverage for the dependent if:

- You are no longer paying premiums because your employer no longer owes you compensation; or
- You have terminated employment with the employer and have not elected to continue coverage.

WHEN COVERAGE ENDS

Your eligibility for coverage will terminate at the end of the month following the month your employment terminates for any of these reasons:

- You become unemployed. Termination of your certificate for this reason applies only if you receive your coverage through your employer.
- You become ineligible for coverage under this certificate. See *Coverage Changes* in this section.

If you cease Active Work because of sickness, injury, lay-off, or leave of absence, your coverage may be continued, provided you pay any required premiums. Arrangements for paying the premiums should be made in the Department of Human Resource Services-Benefits office, 3350 Beardshear Hall, Iowa State University. If you elect to discontinue your coverage while you are on lay-off or an approved Active Work.

leave of absence, you may re-enroll within 31 days after the date you return to work. In addition, by paying the required premium, your coverage may be continued beyond the date it would normally terminate. **Please note:** When both Federal and State-required continuation are available to you and/or your dependents, a choice must be made. Thus, the advantages and disadvantages of Federal vs. State continuation should be carefully weighed before either is chosen. If you are interested in continuing your coverage beyond the date it would normally terminate, you should consult with the University before your coverage terminates.

Coverage for all of your dependents will terminate on the earlier of:

- the date dependent coverage is removed from the group plan; or
- the date your employee coverage ceases.

Coverage for any one Dependent will terminate on the last day of the calendar month following the month in which he or she ceases to be your dependent. However, coverage will be continued beyond the maximum age for a dependent child who is incapable of self-support because of a physical or mental disability and is dependent on you for primary support. You must apply for this continuation within 31 days after the child reaches the maximum age. In addition, under certain conditions, your dependent's coverage may be continued beyond the date it would normally terminate.

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

- ISU decides to discontinue coverage or replaces this coverage.
- Delta Dental decides to terminate coverage of all similar certificates by giving written notice to us 30 days prior to termination.

Your coverage will end if either of the following occurs:

- You use this certificate fraudulently or you fraudulently misrepresent or conceal material facts in your application. If this happens, Delta Dental will recover any claim payments we made.
- You or ISU fails to make payments to Delta Dental when due.

Authority to Terminate, Amend, or Modify

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

CONTINUED COVERAGE

There are some federal and state laws that may affect your coverage with us. 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 and your eligible dependents 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, or if your work hours are reduced to the point that you are no longer eligible for coverage.
- Divorce or legal separation.
- The employee covered under this certificate becomes eligible for Medicare.
- Dependent children are no longer considered dependent by our eligibility rules.
- The employer from whom the covered employee retired files bankruptcy under federal law.

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

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

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

Length of Coverage under COBRA

Continuation coverage ends at the earliest of one of these events:

- The last day of the 18-, 29-, or 36-month maximum coverage period, whichever is applicable.
- 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 pre-existing 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.

Coverage Continuation Under Iowa Law

Under Chapter 509B of the Iowa Code, you may be eligible to continue your coverage for up to nine months if both of the following are true:

- You lose the coverage you have been receiving through your employer or group sponsor.
- You have been covered by your plan continuously for the last three months.

Your employer or group sponsor must provide you with written notice, telling you of your right to continue your coverage within 10 days of the last day you are considered employed or your coverage ends.

After receiving the notice, you have 10 days to notify your employer or group sponsor that you want to continue your coverage. Your request should be written. Assuming you received the proper notice, the right to continue your coverage ends 31 days after the date of termination of your employment or the date you were given notice of your right to continue this program, whichever comes later.

If you lose your coverage because of a divorce, an annulment, or the death of the employee, the employer or group sponsor providing the coverage must be notified within 31 days.

Not every benefit given to active employees may be available under your continued coverage. You will be responsible for paying any premiums to your employer or group sponsor for the continuation of this plan.

If you lose your coverage and think this law applies to you, contact your employer or group sponsor for help with any necessary paperwork and for information on the cost of continuing your coverage.

COVERAGE CHANGES EVENTS CHANGING COVERAGE

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

Active Duty in the Military of a dependent 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 a dependent.

***Death.**

Dependent Child (who is *not* a full-time student or permanently disabled) reaches age 19.

Divorce, Annulment, or Legal Separation.

Exhaustion of COBRA Coverage.

Marriage. a retired employee age 65 or older may only add a dependent spouse to a two-person plan.

Marriage of a dependent child.

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

***Please note:** The dependent spouse or domestic partner and dependent children of a deceased retired employee or a deceased employee who would qualify for coverage as a retired employee, may remain covered under the University’s plan, provided a family or two-person contract is in force at the time of death, and the dependent spouse or domestic partner is not eligible for other group coverage. The dependent spouse or domestic partner may continue to be covered until the earlier of the date he or she is eligible for other group coverage; or the date of his or her death. The dependent children may continue to be covered until the earlier of the date the dependent spouse or domestic partner’s coverage terminates; or the date the child ceases to qualify as a dependent.

NOTIFICATION OF CHANGE

You must notify ISU within 31 days of the date of the event that changes the status of your certificate. You can ask your employer or group sponsor to help you make this request. If a change to your certificate 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 dependent 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 certificate is terminated for fraud, misrepresentation, or the concealment of material facts:

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

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

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 family agree to all of the following:

- You will let us know about any potential claims or rights of recovery related to the illness or injury;
- You will furnish any information and assistance that we determine we will need to enforce our rights under this 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 covered family member(s) must notify us if you have the potential right to receive payment from someone else. You must cooperate with us to ensure that our rights to subrogation are protected.

OTHER INFORMATION NOTICE

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

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

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

NONASSIGNMENT

Benefits for covered services in this certificate are for 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 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.

SUMMARY PLAN DESCRIPTION

PLAN NAME

Iowa State University Dental Plan
Comprehensive Option
Basic Option

PLAN SPONSOR

Iowa State University of Science and Technology

EMPLOYER IDENTIFICATION NUMBER

42-6004224

PLAN NUMBER

501

PLAN YEAR ENDS

January 31

PARTICIPANTS

All persons who are Employees as defined under the Coverage Eligibility portion of the YOUR CERTIFICATE section of this certificate.

PLAN ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS

Iowa State University of Science and Technology
Department of Human Resource Services-Benefits office
3350 Beardshear Hall
Ames, Iowa 50011
Telephone Number: (515) 294-7680

PLAN COSTS

Active Employees: You are required to contribute toward the cost of family coverage. The contribution will be deducted from your pay at a rate established by the University. If you are employed on other than a 12 month basis, the necessary amount will be deducted from your last regular paycheck to maintain coverage for the off duty period. For example, if you are employed on a regular nine month basis and you will be returning to regular employment with the commencement of classes in August, a deduction will be made from your May 31st paycheck to cover your coverage through August 31st.

Retired Employees: The University will not contribute toward the cost of Retiree coverage. You must pay the required premiums. Arrangements for paying the premiums should be made in the Department of Human Resource Services-Benefits Office, 3350 Beardshear Hall, Iowa State University.

TYPE OF PLAN

Welfare: Dental

TYPE OF ADMINISTRATION

Contract

BENEFITS ADMINISTERED BY

Delta Dental of Iowa
2401 S.E. Tones Dr., Suite #13
Ankeny, Iowa 50021

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

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

**www.deltadentalia.com
Claims@deltadentalia.com
Enrollment@deltadentalia.com**