



# GROUP DENTAL PLAN

## ISU DENTAL PLAN COMPREHENSIVE OPTION AND BASIC OPTION

### DELTA DENTAL PPO PLUS PREMIER® SUMMARY PLAN DESCRIPTION

#### CLAIMS ADMINISTERED BY DELTA DENTAL OF IOWA

***Important Caution:*** A document like this Summary Plan Description *must* be reviewed and prepared by the employer's legal counsel *before* it is adopted by the employer and distributed to its plan participants. In addition to this Summary Plan Description, the employer should prepare and adopt its own separate plan document[s].

Effective Date: 01/01/2021  
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Form Number: DDCERT 0120



# INTRODUCTION

Iowa State University maintains the Iowa State University Group Dental Plan (“the Dental Plan”) for the exclusive benefit of and to provide dental benefits to their eligible full-time employees, their eligible spouses, and eligible children. These benefits, including information about who is eligible to receive benefits, are summarized in this document, which constitutes the Summary Plan Description.

Claims for reimbursement of dental benefits under the Dental Plan are administered by Delta Dental of Iowa (hereafter “Delta Dental”) pursuant to a contract between Iowa State University and Delta Dental.



# INTERPRETING THIS SUMMARY PLAN DESCRIPTION

It is important that you understand all parts of this Summary Plan Description to get the most out of your benefits. To help make the information easier to understand, we use the words *you* and *your* to refer to you and your other eligible Covered Persons who have enrolled for coverage under this Dental Plan. In other places, we use the word *participant* to refer to the employee enrolled under the Dental Plan and the words *beneficiary* or *beneficiaries* to refer to the participant's eligible Covered Persons who are enrolled under the Dental Plan. The words, *we*, *us*, and *our* refer to Iowa State University, the Plan Administrator for your Dental Plan. Finally, the term *Plan Sponsor or group sponsor* refers to your employer or other sponsor of this Dental Plan.

We will interpret the provisions of this Summary Plan Description and determine the answers to all questions that arise under it. Pursuant to a contract with Delta Dental, we have delegated our administrative discretion to initially determine whether you meet the Dental Plan's written eligibility requirements, or to interpret any other term of this Dental Plan. In addition, if any benefit in this Summary Plan Description is subject to a determination of dental necessity and dental appropriateness, Delta Dental will make that factual determination. Our interpretations and determinations and those of Delta Dental are final and conclusive.

In this Summary Plan Description we sometimes refer to certain laws and regulations. Laws and regulations can and do change from time to time. If you have a question as to how laws and regulations may apply to your coverage please contact your employer or group sponsor.

To administer your benefits properly, there are certain rules you must follow. Different rules appear in different sections of this Summary Plan Description. We urge you to become familiar with the entire Summary Plan Description.



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# GENERAL INFORMATION ABOUT THE DENTAL PLAN

For your convenience, we have listed below certain basic, plan-identifying information.

Plan Name:	Iowa State University Dental Plan Comprehensive Option Basic Option
Type of Plan:	A group health plan (a type of welfare benefits plan).
Plan Year Ends:	December 31
Plan Number:	501
Original Effective Date:	February 1, 1997. The Dental Plan has been amended several times since its original effective date.
Plan Sponsor:	Iowa State University 3770 Beardshear Hall Ames, IA 50011 515-294-4800
Plan Sponsor's Employer Identification Number:	42-6004224
Plan Administrator:	Iowa State University of Science and Technology Department of Human Resource Services Benefits Office 3770 Beardshear Hall Ames, IA 50011 515-294-4800

Claims Administrator:

Delta Dental of Iowa  
1-800-544-0718

Named Fiduciary:

Iowa State University  
3770 Beardshear Hall  
Ames, IA 50011  
515-294-4800

**PLAN COSTS:**

**Active Employees:** You are required to contribute toward the cost of 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 the 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, 3770 Beardshear Hall, Iowa State University.

**Agent for Service of Legal Process:**

Iowa State University of Science and Technology  
Department of Human Resource Services  
Benefits Office  
3770 Beardshear Hall  
Ames, IA 50011  
515-294-4800

**Legal Plan Document & Disclaimer:** This Summary Plan Description summarizes the principal features of the Dental Plan in a general manner. The complete terms and conditions of the Dental Plan are contained in the Group Dental Plan legal document adopted by Iowa State University and in portions of this Summary Plan Description. You can obtain a copy of the Group Dental Plan legal document from the Plan Administrator.

# 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 Summary Plan Description.

COMPREHENSIVE OPTION	PPO	PREMIER	NON-PAR
<b>Deductible</b>	\$50/\$50	\$50/\$50	\$50/\$50
<b>Deductible Apply to Check-Ups and Teeth Cleaning</b>	No	No	No
<b>Annual Maximum</b>	\$1,500	\$1,500	\$1,500
<b>Orthodontic Lifetime Maximum</b>	\$2,000	\$2,000	\$2,000
Benefit Categories	MEMBER COINSURANCE		
<b>Check-Ups and Teeth Cleaning</b> (Diagnostic and Preventive Services)	0%	0%	0%
<ol style="list-style-type: none"> <li>1. Dental Cleaning</li> <li>2. Oral Evaluation</li> <li>3. Fluoride Applications</li> <li>4. X-rays</li> <li>5. Sealant Applications</li> <li>6. Space Maintainers</li> <li>7. Bacteriologic Cultures</li> <li>8. Histopathologic Exams</li> <li>9. Diagnostic Casts</li> <li>10. Emergency Treatment</li> <li>11. Biopsy of Oral Tissue</li> <li>12. Pulp Vitality</li> </ol>			

**COMPREHENSIVE OPTION****PPO****PREMIER****NON-PAR**

<b>Benefit Categories</b>	<b>MEMBER COINSURANCE</b>		
<b>Cavity Repair and Tooth Extractions</b> (Routine and Restorative Services) <ol style="list-style-type: none"> <li>1. General Anesthesia/Sedation</li> <li>2. Restoration of Decayed or Fractured Teeth</li> <li>3. Limited Occlusal Adjustment</li> <li>4. Routine Oral Surgery</li> <li>5. Posterior Composite</li> <li>6. Space Maint. Recementing</li> <li>7. Antibiotic Drug Injection</li> <li>8. Consultations</li> </ol>	20%	20%	20%
<b>Root Canals</b> (Endodontic Services) <ol style="list-style-type: none"> <li>1. Apicoectomy</li> <li>2. Direct Pulp Cap</li> <li>3. Pulpotomy</li> <li>4. Retrograde Fillings</li> <li>5. Root Canal Therapy</li> </ol>	20%	20%	20%
<b>Gum and Bone Diseases</b> (Periodontal Services) <ol style="list-style-type: none"> <li>1. Conservative Procedures</li> <li>2. Complex Procedures</li> <li>3. Maintenance Therapy</li> </ol>	20%	20%	20%
<b>High Cost Restorations</b> (Cast Restorations) <ol style="list-style-type: none"> <li>1. Cast Restorations               <ol style="list-style-type: none"> <li>a. Crowns</li> <li>b. Inlays</li> <li>c. Onlays</li> <li>d. Posts and Cores</li> </ol> </li> </ol>	50%	50%	50%

**COMPREHENSIVE OPTION****PPO****PREMIER****NON-PAR**

<b>Benefit Categories</b>	<b>MEMBER COINSURANCE</b>		
<b>Dentures and Bridges</b> (Prosthetics)	50%	50%	50%
<ul style="list-style-type: none"> <li>1. Bridges</li> <li>2. Dentures</li> <li>3. Denture Relining</li> <li>4. Repairs and Adjustments</li> <li>5. Recementing</li> <li>6. Dental Implants</li> </ul>			
<b>Straighter Teeth*</b> (Orthodontics)	50%	50%	50%

\*Benefit Category: **Straighter Teeth** has a separate \$50 lifetime deductible.

<b>BASIC OPTION</b>	<b>PPO</b>	<b>PREMIER</b>	<b>NON-PAR</b>
<b>Deductible</b>	\$25/\$25	\$25/\$25	\$25/\$25
<b>Deductible Apply to Check-Ups and Teeth Cleaning</b>	No	No	No
<b>Annual Maximum</b>	\$750	\$750	\$750
<b>Benefit Categories</b>	<b>MEMBER COINSURANCE</b>		
<b>Check-Ups and Teeth Cleaning</b> (Diagnostic and Preventive Services)	0%	0%	0%
<ol style="list-style-type: none"> <li>1. Dental Cleaning</li> <li>2. Oral Evaluation</li> <li>3. Fluoride Applications</li> <li>4. X-rays</li> <li>5. Sealant Applications</li> <li>6. Space Maintainers</li> <li>7. Bacteriologic Cultures</li> <li>8. Histopathologic Exams</li> <li>9. Diagnostic Casts</li> <li>10. Emergency Treatment</li> <li>11. Biopsy of Oral Tissue</li> <li>12. Pulp Vitality</li> </ol>			
<b>Cavity Repair and Tooth Extractions</b> (Routine and Restorative Services)	50%	50%	50%
<ol style="list-style-type: none"> <li>1. General Anesthesia/Sedation</li> <li>2. Restoration of Decayed or Fractured Teeth</li> <li>3. Limited Occlusal Adjustment</li> <li>4. Routine Oral Surgery</li> <li>5. Posterior Composite</li> <li>6. Sapce Maint. Recementing</li> <li>7. Antibiotic Drug Injection</li> <li>8. Consultations</li> </ol>			
<b>Root Canals</b> (Endodontic Services)	50%	50%	50%
<ol style="list-style-type: none"> <li>1. Apicoectomy</li> <li>2. Direct Pulp Cap</li> <li>3. Pulpotomy</li> <li>4. Retrograde Fillings</li> <li>5. Root Canal Therapy</li> </ol>			

**BASIC OPTION****PPO****PREMIER****NON-PAR**

<b>Benefit Categories</b>	<b>MEMBER COINSURANCE</b>		
<b>Gum and Bone Diseases</b> (Periodontal Services) <ol style="list-style-type: none"> <li>1. Conservative Procedures</li> <li>2. Complex Procedures</li> <li>3. Maintenance Therapy</li> </ol>	50%	50%	50%
<b>High Cost Restorations</b> (Cast Restorations) <ol style="list-style-type: none"> <li>1. Cast Restorations               <ol style="list-style-type: none"> <li>a. Crowns</li> <li>b. Inlays</li> <li>c. Onlays</li> <li>d. Posts and Cores</li> </ol> </li> </ol>	50%	50%	50%
<b>Dentures and Bridges</b> (Prosthetics) <ol style="list-style-type: none"> <li>1. Denture Relining</li> <li>2. Repairs and Adjustments</li> <li>3. Recementing of Bridges</li> </ol>	50%	50%	50%

# DENTAL PLAN ADMINISTRATION

The administration of the Dental Plan is under the supervision of the Plan Administrator, Iowa State University. The Benefits Office of Iowa State University acts on behalf of the Plan Administrator. The principal duty of the Plan Administrator is to see that the terms of the Dental Plan are carried out in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The Company bears all costs of administering the Plan and for paying all claims.

Under a contract with Delta Dental, the Plan Administrator has delegated its authority to Delta Dental to act as the Claims Administrator for the Dental Plan and to determine the initial eligibility for and the amount of any benefits payable under the Dental Plan and for prescribing the procedures to be followed and the forms to be used by you pursuant to the Dental Plan. We have further delegated to Delta Dental, as the Claims Administrator, the authority to require you to furnish it with such information as it determines is necessary for the proper administration of the Dental Plan. If you have general questions regarding the Dental Plan, please contact the Plan Administrator. However, if you have specific questions concerning eligibility for and/or the amount of any benefits payable under the Dental Plan, please contact Delta Dental.



# IMPORTANT INFORMATION

Your Delta Dental PPO Plus 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 PPO Program is their panel of Delta Dental PPO Dentists hereafter referred to as “PPO Panel Dentists”. You may seek care from almost any dentist you wish. However, there are usually advantages when you receive services from PPO Panel Dentists or Participating Delta Dental Dentists. “Participating Delta Dental Dentists,” in this Summary Plan Description, are dentists who participate with Delta Dental of Iowa’s Premier Program or their local Delta Dental Member Company’s Premier Program, but do not participate as a PPO Panel Dentist.

Your payment responsibilities are also outlined in this section of your Summary Plan Description. 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 PPO Panel Dentist or a Participating Delta Dental Dentist.

## WHAT YOU SHOULD KNOW ABOUT PPO PANEL DENTISTS

Delta Dental has contracting relationships with PPO Panel Dentists throughout the state. Delta Dental’s contracts with PPO Panel Dentists include an applicable fee schedule or the Maximum Plan Allowance. See **Understanding Payment Vocabulary** later in this section. This applicable fee schedule or Maximum Plan Allowance usually results in savings to you. When you receive services from PPO Panel Dentists who participate with Delta Dental of Iowa or any other Delta Dental Member Company, all of the following statements are true:

- PPO Panel Dentists agree to accept their local Delta Dental Member Company’s PPO Schedule, which may result in savings for Covered Services.
- Your deductible or coinsurance responsibility may be **less** for Covered Services you receive from a PPO Panel Dentist than it would be from a Participating Delta Dental Dentist or a nonparticipating dentist.
- PPO Panel Dentists agree to file claims for you.
- Delta Dental settles claims directly with PPO Panel 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.

- PPO Panel Dentists agree to handle The Notification Program for you. See **The Notification Program** section.
- PPO Panel Dentists agree that he or she will only be paid the lesser of (i) his or her Billed Charge, or (ii) the applicable fee schedule or Delta Dental's Maximum Plan Allowance for Covered Services. See **Understanding Payment Vocabulary** later in this section.

## **WHAT YOU SHOULD KNOW ABOUT PARTICIPATING DELTA DENTAL DENTISTS**

We have contracting relationships with Participating Delta Dental Dentists throughout the state. Our contracts with Participating Delta Dental Dentists include payment arrangements based on Delta Dental's applicable fee schedule or the Maximum Plan Allowance. See **Understanding Payment Vocabulary** later in this section. The applicable fee schedule or Maximum Plan Allowance usually results in savings to you. When you receive services from Participating Delta Dental Dentists who participate with Delta Dental of Iowa or a Delta Dental Member Company, all of the following statements are true:

- Participating Delta Dental Dentists agree to accept their local Delta Dental Member Company's payment arrangement, which may result in savings for Covered Services
- Your deductible or coinsurance responsibility may be more for Covered Services you receive from a Participating Delta Dental Dentist who is not a PPO Panel Dentist.
- Participating Delta Dental Dentists agree to file claims for you.
- Delta Dental settles claims directly with Participating Delta Dental Dentists. See **Understanding Amounts You Pay to Share Costs** later in this section.
- Participating Delta Dental Dentists agree to handle The Notification Program for you. See **The Notification Program** section.
- Participating Delta Dental Dentists agree that he or she will only be paid the lesser of (i) his or her billed charge, or (ii) the applicable fee schedule or Delta Dental's Maximum Plan Allowance for Covered Services. See **Understanding Payment Vocabulary** later in this section.

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

When you receive services from nonparticipating (non-par) dentists, you will not receive any of the advantages that Delta Dental contracts with PPO Panel Dentists or Participating Delta Dental Dentists offer. As a result, when you receive services from nonparticipating dentists, all of the following statements are true:

- Delta Dental does not have contracting relationships with nonparticipating dentists and they do not agree to accept their local Delta Dental Member Company’s PPO payment arrangement or any other payment arrangement. This means you are responsible for any difference between your nonparticipating dentist’s Billed Charge and the Delta Dental nonparticipating dentist fee schedule. See **Understanding Payment Vocabulary** later in this section.
- Nonparticipating dentists are not responsible for filing your claims.
- Delta Dental settles claims with you, not nonparticipating dentists. However, for Iowa nonparticipating dentists, the payment will be mailed to you but the check may be payable to the nonparticipating dentist. You are responsible for paying your dentist in full, including any Deductible, Member Coinsurance and non-approved charges you may owe. See **Understanding Payment Vocabulary** later in this section.
- Nonparticipating dentists do not agree to handle The Notification Program for you. See **The Notification Program** section.
- Nonparticipating dentists may charge for “infection control,” which includes the costs for services and supplies associated with sterilization procedures. You are responsible for any extra charges billed by a nonparticipating dentist for “infection control.” (All dentists are legally required to follow certain guidelines to protect their patients and staff from exposure to infection. However, PPO Panel Dentists and Participating Delta Dental Dentists incorporate these costs into their normal fees and do not charge an additional fee for “infection control.”)
- Nonparticipating dentists do not agree that he or she will only be paid the lesser of (i) his or her Billed Charge, or (ii) the applicable fee schedule or Delta Dental’s Maximum Plan Allowance for Covered Services, as do Participating Delta Dental Dentists in certain situations. See **Understanding Payment Vocabulary** later in this section.

## **QUESTIONS DELTA DENTAL ASKS 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, Delta Dental first answers all of the following questions:

### **Is the Procedure Dentally Necessary?**

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

- The diagnosis is proper; and

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

### **Is the Procedure Dentally Appropriate?**

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

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

### **Is the Procedure Subject to Contract Limitations?**

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

- Amounts for procedures that are not dentally necessary or dentally appropriate.
- Amounts for procedures that are not covered by this Dental Plan. 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 may not be 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 Summary Plan Description.
- Any difference between the dentist's Billed Charge and the applicable fee schedule or the Maximum Plan Allowance. **Please note:** This only applies if you receive services from a nonparticipating dentist or procedures that are not Covered Services.
- Deductible(s) and Member Coinsurance.

## **DELTA DENTAL'S PAYMENT POLICY**

Delta Dental's policy is to send payment for treatment after it is completed—not before.

For example, Delta Dental will send 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**

### **WAITING PERIOD**

A waiting period is the amount of time you and/or your other eligible Covered Person(s) must wait before certain benefits are available under this Dental Plan. Waiting Periods do not apply to accident care.

Waiting periods apply when:

- You initially decline coverage for yourself or your other eligible Covered Person(s) and later enroll.

If waiting periods apply to you, the Covered Person requiring dental services, must be covered by this Dental Plan 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**

### **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. 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 Services**

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

### **Delta Dental Member Company**

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

### **Eligible Covered Person(s)**

Covered Person means any individual eligible for dental benefits under a dental program that is insured or administered by Delta Dental (or by a Delta Dental Member Company). An Eligible Covered Person is an employee who has met the employer's eligibility requirements and the employee's eligible Spouse and eligible Child(ren).

### **Maximum Plan Allowance**

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

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

### **PPO Schedule**

The PPO Schedule is a reduced fee schedule for certain Covered Services. Some Participating Delta Dental Dentists, who are other than general practice dentists, will be considered PPO Panel Dentists except that their payment will be based on the lesser of their Billed Charge or the Maximum Plan Allowance rather than on the PPO Schedule. The Participating Delta Dental Dentists who have agreed to be PPO Panel Dentists will be listed in the Delta Dental of Iowa PPO Panel Dentist Directory.

## **UNDERSTANDING AMOUNTS YOU PAY TO SHARE COSTS**

### **Deductible**

Deductible is the fixed dollar amount you pay for Covered Services for each Eligible Covered Person in a Benefit Period before benefits are available under this Dental Plan. This amount is shown on the **Summary of Benefits and Payment** chart at the beginning of this Summary Plan Description, if applicable.

### **Lifetime Deductible**

Lifetime Deductible is the fixed dollar amount you pay for Covered Services in a lifetime before Orthodontic benefits are available under this Dental Plan. This amount is shown on the Summary of Benefits and Payment Chart at the beginning of this Summary Plan Description.

### **Member Coinsurance**

Member 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 Summary Plan Description.

Member Coinsurance payments begin once you meet any applicable Deductible amounts. Member Coinsurance is calculated off the applicable fee schedule or the Maximum Plan Allowance, as the case may be. In general, the percentage of

coinsurance you pay depends on the benefit category of the service you receive and participation status of your dentist.

### **CheckUp Plus<sup>SM</sup> (BASIC OPTION)**

CheckUp Plus is a plan design that waives diagnostic and preventive dental service costs from a Covered Person's Benefit Period Maximum.

CheckUp Plus promotes regular visits to the dentist for exams, x-rays and cleanings – which can improve overall health.

### **Benefit Period Maximum or Annual Maximum**

The Benefit Period Maximum or Annual Maximum is the maximum benefit each Covered Person is eligible to receive for certain Covered Services in a Benefit Period. The Benefit Period Maximum is reached from claims settled under this Summary Plan Description in a Benefit Period. This amount is shown on the **Summary of Benefits and Payment** chart at the beginning of this Summary Plan Description.

Services received from **Benefit Category: Straighter Teeth** are excluded from your benefit period maximum.

### **Lifetime Maximum**

In a Covered Person'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 Summary Plan Description.

## **HELPING WHEN YOU HAVE QUESTIONS**

If you have any questions after reading this Summary Plan Description, please call Delta Dental. For your convenience, Delta Dental has listed their toll-free number on the back cover of this Summary Plan Description.



# 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**

Oral evaluations include all types of dental examinations including preventive examinations, comprehensive examinations, consultations, and problem focused evaluations.

*Limitation:* These evaluations/examinations are a benefit twice per benefit period.

### **Topical Fluoride Applications**

Professionally administered procedure in which the dental surfaces are coated with a fluoride solution or gel to discourage decay.

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

### **X-Rays:**

#### **Bitewing X-Rays**

Bitewing is an x-ray that shows the crowns of the upper and lower teeth simultaneously and that is held in place by a tab between the teeth.

*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 or panoramic x-rays are a benefit only once every 5 consecutive years.

#### **Extraoral X-Rays**

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

A radiographic image used to look at areas of the oral cavity and jaws that are not closely associated with the teeth.

### **Occlusal X-Rays**

Occlusal x-rays capture all the upper and lower teeth in one image while the film rests on the biting surface of the teeth.

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

### **Periapical X-Rays**

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

### **Cephalometric X-Rays**

*Limitation:* These x-rays are a benefit only once every 2 consecutive years. A radiographic image which captures the entire skull and profile.

### **Bacteriologic Cultures, Histopathologic Exams, Pulp Vitality Test, Diagnostic Casts**

*Limitation:* Bacteriologic Cultures, histopathologic exams, pulp vitality tests, and diagnostic casts are a benefit only once every 2 consecutive years.

### **Sealant/Preventive Resin Applications**

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

*Limitation:* Sealant/Preventive Resin applications are a benefit once per permanent first and second molars for eligible beneficiaries who are children under age 15.

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

### **Space Maintainers for Missing Back Teeth**

Space maintainers are passive appliances designed to prevent tooth movement.

*Limitation:* Space maintainers are a benefit only for eligible beneficiaries who are 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.

### **Limited Occlusal Adjustment**

Reshaping the biting surfaces of one or more teeth.

*Limitation:* Limited occlusal adjustment is a benefit only twice every 12 consecutive months.

### **Routine Oral Surgery**

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

### **Antibiotic Drug Injections**

Antibiotic drug injection is an injection of antibiotics that inhibits or destroys bacterial growth in a specific area of the mouth.

### **Consultations**

Consultations between two dentists about your course of treatment. This procedure replaces the Oral Evaluations benefit (exams) described under Check-Ups and Teeth Cleaning earlier in this section.

### **Alveoplasty**

Surgical procedure for recontouring supporting bone, sometimes in preparation for a prosthesis.

## **ROOT CANALS ENDODONTIC SERVICES**

### **Apicoectomy/Periradicular Surgery**

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

### **Direct Pulp Cap**

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

### **Pulpotomy**

Removing the coronal portion of the pulp as part of root canal therapy. When performed on a baby (primary) tooth, pulpotomy is the only procedure required for root canal therapy.

### **Retrograde Fillings**

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

### **Root Canal Therapy**

Treating an infected or injured pulp to retain tooth function. This procedure generally involves removal of the pulp and replacement with an inert filling material.

## **GUM AND BONE DISEASES PERIODONTAL SERVICES**

*Please note:* Certain procedures in this category should receive Delta Dental's review *before* they are performed. See **The Notification Program** section.

### **Full Mouth Debridement**

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

### **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 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 and represents four or more contiguous teeth or bounded teeth spaces.

## **Periodontal Maintenance Therapy**

Includes various maintenance services such as pocket depth measurements, dental cleaning (oral prophylaxis), removal of stain, and root planing and scaling.

*Limitation:* This procedure may follow conservative or complex periodontal therapy. When this procedure immediately follows complex or conservative periodontal therapy, benefits are available up to four times in the first Benefit Period and twice per Benefit Period thereafter. *This procedure replaces the dental cleaning benefit (prophylaxis) described under Check-Ups and Teeth Cleaning earlier in this section.*

## **HIGH COST RESTORATIONS CAST RESTORATIONS**

**Please note:** Certain procedures in this category should receive Delta Dental's review *before* they are performed. See **The Notification Program** section.

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

### **Cast Restorations for Complicated Tooth Decay or Fracture**

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

### **Crowns**

Restoring form and function by covering and replacing the visible part of the tooth with a precious metal, porcelain-fused-to-metal, or porcelain crown. *Crowns placed for the primary purpose of periodontal splinting, cosmetics, altering vertical dimension, restoring your bite (occlusion), or restoring a tooth due to attrition, abrasion, erosion, and abfraction are not a benefit.* *Limitation:* Crowns are a benefit only if the tooth cannot be restored with a routine filling.

## **Inlays**

Restoring a tooth with a cast metallic or porcelain filling.

*Limitation:* **Inlay benefits are limited to the amount paid for a silver (amalgam) filling.**

## **Onlays**

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

## **Posts and Cores**

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

## **Recementation of Cast Restorations**

Recementation of an inlay, onlay, or crown that has become loose.

*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:* Certain procedures in this category should receive Delta Dental's review *before* they are performed. See **The Notification Program** section.

*Please note:* Dentures, dental implants, 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.

## **Dental 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**

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

## **Tissue Conditioning**

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

## **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) CORRECTIVE ORTHODONTICS**

Corrective Orthodontics services are orthodontic procedures, or directly associated procedures, that move teeth to correct an abnormal dental relationship between and among teeth.

### **Benefits received for Corrective Orthodontics apply to the Lifetime Maximum.**

Services for proper alignment of teeth. Orthodontics are a benefit for all Covered Persons; adults, eligible children and full-time students.

When an Corrective 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 payments over the course of treatment, providing coverage still exist.

If Corrective 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.



# SERVICES NOT COVERED

This Dental Plan *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 Dental Plan. Call Delta Dental if you are unsure if a certain service is covered. For your convenience, Delta Dental has listed their toll-free number on the back cover of this Summary Plan Description.

## **EXCLUSIONS**

### **Anesthesia or Analgesia**

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

### **Broken Appointments**

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

### **Complete Occlusal Adjustment**

You are not covered for services or supplies used for revision or alteration of the functional relationships between upper and lower teeth.

### **Complications of a Non-Covered Procedure**

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

### **Congenital Deformities**

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

### **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.

**Desensitizing Medicament or Resin**

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

**Drugs**

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

**Effective Date**

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

**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.

**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 Dental Plan, 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.

**Plaque Control Programs, Oral Hygiene Instructions, and Dietary Instructions**

You are not covered for services or supplies used for plaque control, oral hygiene, and/or dietary instructions.

**Prosthetics (BASIC OPTION)**

You are not covered for prosthetics, including bridges and dentures.

### **Provisional Crowns, Bridges or Dentures**

You are not covered for services or supplies for provisional crowns, bridges or dentures.

### **Repair, Replacement or Duplication of Orthodontic Appliances**

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

### **Services 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.

### **Straighter Teeth - Corrective Orthodontics (BASIC OPTION)**

You are not covered for orthodontics under the Basic Option.

### **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.

### **Termination**

Whether or not Delta Dental has approved a treatment plan, you are not covered for treatment received after the date your coverage terminates.

### **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. 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 dental plan.

**Unerupted Teeth**

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

**Workers' Compensation**

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

# THE NOTIFICATION PROGRAM

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

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 Dental Plan.

## 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 Delta Dental of Iowa before you receive the following benefits:

- Complex Periodontal Surgery
- High Cost Restorations including Crowns, Onlays, and Bridges
- Dental Implants

**You should also notify Delta Dental of Iowa before you receive treatment from any benefit category that will exceed \$200.**

Delta Dental's 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 Delta Dental determine if the procedure is a benefit of your Dental Plan 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 — PPO Panel Dentists and Participating Delta Dental Dentists agree to file for you.

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

## Where to Send a Treatment Plan

Submit the proposed treatment plan, along with x-rays and supporting information to:

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

## THE TREATMENT PLAN REVIEW

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

- **Accept** it as submitted.
- **Recommend an alternative benefit.** If Delta Dental asks you to receive an independent diagnosis from a dentist of Delta Dental's choice, Delta Dental will pay for the exam.
- **Deny the treatment plan** because:
  - the procedure is not a benefit of this Dental Plan;
  - you did not receive an independent exam after Delta Dental asked you to; or
  - the procedure is not dentally necessary and dentally appropriate.

## Reconsideration Request of Treatment Plan

If Delta Dental denies a treatment plan, you can resubmit it with additional documentation and ask Delta Dental, in writing, to reconsider. If necessary, Delta Dental will ask you to receive an independent diagnosis from an independent dentist of Delta Dental's choice—Delta Dental will pay for the exam.

**Please note:** Although Delta Dental may approve a treatment plan, neither Delta Dental nor this Dental Plan are necessarily liable for the actual treatment you receive from your dentist.

# FILING CLAIMS

Once you receive dental services, Delta Dental needs to receive a claim to determine the amount of your benefits. The claim lets Delta Dental 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 —PPO Panel Dentists and Participating Delta Dental Dentists file for you.

## **WHEN TO FILE YOUR CLAIM**

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

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

If you need a claim form or have any questions after reading this section, please call Delta Dental or visit their website [www.deltadentalia.com](http://www.deltadentalia.com). For your convenience, Delta Dental has listed their toll-free number on the back cover of this Summary Plan Description. If you must file your own claim, send it to the following address:

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

## **FILING WHEN YOU HAVE OTHER COVERAGE COORDINATION OF BENEFITS**

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



## What You Should Do

When you receive services, you need to let Delta Dental 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 Delta Dental 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 Delta Dental 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. Delta Dental will contact you if any additional information is needed.

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

## What Delta Dental Will Do

There are certain rules Delta Dental follows to help determine which coverage pays first when you have other insurance or coverage that provides the same or similar benefits as this Dental Plan. Here are some of the rules:

- The coverage **without coordination of benefits** pays first when both coverages are through a group sponsor such as an employer, but one coverage has coordination of benefits and one does not.
- The dental benefits of your **auto coverage** will pay before this coverage if the auto coverage does not have a coordination of benefits provision.
- The coverage which you have as **an employee or contract holder** participant pays before the coverage which you have as a plan beneficiary spouse or child.
- The coverage you have as **the result of your active employment** pays before coverage you hold as a retiree or under which you are not actively employed.
- The coverage with the **earliest continuous effective date** pays first when none of the above rules apply.

If none of the guidelines just mentioned apply to your situation, Delta Dental will use the Coordination of Benefits (COB) guidelines adopted by the Iowa Insurance Division to determine payment to you or to your PPO Panel Dentist or Participating Delta Dental Dentist (as the case may be).

## **What You Should Know About Beneficiaries Who Are Children**

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

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

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

## **DENIED CLAIMS AND APPEALS PROCEDURES**

### **CLAIM DENIALS**

Pursuant to our contract with Delta Dental, we have delegated the responsibility for evaluating all claims for reimbursement to Delta Dental as the Claims Administrator. Delta Dental will decide your claim within a reasonable time not longer than 30 days after it is received. This time period may be extended, however, where a claim is incomplete or there are other circumstances beyond Delta Dental's control. In such a case, Delta Dental will provide you with written notice of any required extension in the time for them to respond, including the reasons for such an extension and information on the date on which a decision is expected to be made. If an extension is necessary because a claim is incomplete, the written notice to you will also request that you provide Delta Dental with certain additional information within 45 days. The time period for Delta Dental to respond to your claim can be extended for an additional 15 days from the date on which Delta Dental receives the requested additional information.

Delta Dental may obtain the advice of independent dentists or require such other evidence as it deems necessary to decide your claim.

If Delta Dental denies your claim, in whole or in part, you will be furnished with a written notice setting forth the following information:

1. the specific reasons for the denial;
2. reference to the specific provisions of the Dental Plan on which the denial is based;
3. a description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary; and
4. appropriate information as to the steps to be taken if you wish to appeal the decision of Delta Dental, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information.

## **APPEALING A DENIED CLAIM OR ADVERSE BENEFIT DETERMINATION**

### **Your Initial Request For A Review**

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

### **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. After that time, Delta Dental will make the final decision on the claim based on the information they have in your file.

### **Reviewing Records**

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

Send your request to:

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

Delta Dental will review your request and decide your appeal within a reasonable time not longer than 60 days after it is submitted and will notify you of its decision in writing. The individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that person's subordinate. Delta Dental may secure the advice of independent dentists or others and require such evidence as it deems necessary to decide your appeal, except that any dental or other expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial claim. The identity of any dental or other expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be given a notice of denial on review that provides the following information:

1. the specific reason(s) for the denial;
2. the specific provisions of the Dental Plan on which the decision is based;
3. a statement of your right to review (on request and at no charge) relevant documents and other information;
4. if Delta Dental relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request.

# ELIGIBILITY

## COVERAGE ELIGIBILITY

You are eligible to be a participant in the Dental Plan if you are an employee who has met your employer's eligibility requirements or if you are either the eligible spouse or an eligible child of an employee who has met the employer's eligibility 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 during annual open change time. No one is allowed to be added, outside of the annual open change time, unless there is a qualifying event. See Notification of Change on page 50.

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 Iowa State University classifies as a benefits eligible employee. This requires employment for at least 1/2 time or greater and for 9 months or longer if hired after July 1, 2009. For those hired prior to July 1, 2009 without a lapse in employment, and appointment 1/3 time or greater for 9 months or longer qualify as benefits eligible, as determined by Iowa State University.

Retired employees are also eligible for coverage.

***Please note:*** A retired employee means any person who, prior to retirement, was classified as a benefits eligible employee and had 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 June 11, 1990, through July 31, 1990, or December 1996.

***Please note:*** Eligible participant electing the Comprehensive Dental Plan must remain in the Comprehensive option for at least three (3) years and then may only

change plans at the next open change period. If your family status changes during the year, you may change your tier of coverage by not your plan option.

## **WHEN BENEFITS BEGIN**

Your coverage will normally be in force on:

- the date you are hired provided you complete enrollment prior to your initial enrollment deadline assigned by the ISU Benefits Office.

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 eligible spouse and eligible child(ren) will be in force under the same terms except:

- coverage will not be effective unless you are covered for employee coverage; and
- a child acquired after your family coverage is already in force will be covered on the date acquired, provided you complete Notification of Change, see page 50.

In addition, if you make your request more than 31 days after the date you are eligible, you, your eligible spouse, and eligible child(ren) dental coverage will be subject to waiting periods as described in the **Important Information** section of this Summary Plan Description.

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

If you fraudulently use the identification card or misrepresent or conceal material facts in your application, then Delta Dental may terminate your benefits.

## TYPES OF COVERAGE

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

### Active Employees:

- With *single coverage*, you are the only one covered.
- With *employee and spouse coverage*, you and your eligible spouse or domestic partner (of same or opposite-sex) are covered.
- With *employee and child(ren) coverage*, you and your eligible child(ren) are covered.
- With *family coverage*, you, your eligible spouse or domestic partner (of same or opposite-sex), and each of your eligible children are covered and are considered beneficiaries. Each eligible Covered Person must be listed on your dental application for coverage or added later as a new eligible Covered Person.

**Please note:** Spouses or partners who are both employees (double spouse), may not be covered as both “contract holders” and “spouses” under the plan. One must choose to be the “contract holder” and the other will then be the “spouse” of that “contract holder” under the plan. Spouses or partners may elect to change their classifications from “contract holder” to “spouse” status with a qualifying event during a calendar year. Those changing their type of coverage during the calendar year from “contract holder” to “spouse” or vice versa, will have deductible and out-of-pocket credits transferred as well.

### Retired Employees:

- With *single coverage*, you are the only one covered.
- With *employee and spouse coverage*, you and your eligible spouse or domestic partner (of same or opposite-sex) are covered.
- With *employee and child(ren) coverage*, you and your eligible child(ren) are covered.
- With *family coverage*, you, your eligible spouse or domestic partner (of same or opposite-sex), and each of your eligible children are covered and are considered beneficiaries. Each eligible Covered Person must be listed on your dental application for coverage or added later as a new eligible Covered Person.

An eligible child can be your natural child, a child placed with you for adoption or a legally adopted child, a child for whom you have legal guardianship, a stepchild, or a foster child. To be an eligible beneficiary, a child must meet at least one of the following standard requirements:

- The child is under age 26.
- The child is age 26 or older, not married, and a full-time student. For an eligible child to be considered a full-time student they must be enrolled in an accredited institution of higher learning, such as a college, university, nursing, or trade school, and carry enough hours to be classified by the institution as full-time. Full-time student status continues during regularly scheduled school vacation periods, and during absence from class in which enrolled for up to four months due to a physical or mental disability. The disability must be substantiated by a written statement from a physician.
- The child is a dependent of the child's parent and is totally or permanently disabled, either physically or mentally according to IRS guidelines. If the dependent child is permanently disabled, the disability must have existed before the child was age 19 or while the child was a full-time student under 26 years of age, and the child must have had continuous qualifying dental coverage without a break of 63 days or more since the child turned age 19 or while the child was a full-time student under age 26.

A child who has been placed in your home for the purpose of adoption or who you have adopted shall be eligible for coverage as of the date of placement for adoption or as of the date of actual adoption, whichever occurs first, provided you complete Notification of Change, see page 50.

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

If you have a child and we receive a Medical Child Support Order recognizing the child's right to enroll in this Dental Plan and/or any other benefit plan, we will promptly notify both you and the child that the order has been received. We also will inform you and the child of our procedures for determining whether the order is a Qualified Medical Child Support Order. You may obtain, without charge, a copy of QMCSO procedures from your employer or group sponsor.

### **WHEN BENEFITS END**

Your eligibility for benefits under this Dental Plan will terminate at the end of the month for any of these reasons:

- You become ineligible for coverage under this Dental Plan. See *Eligibility* earlier in this section.
- You become unemployed. Termination of your coverage for this reason applies only if you receive your coverage through your employer.



If you cease Active Work because of sickness, injury, layoff, 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, 3770 Beardshear Hall, Iowa State University. If you elect to discontinue your coverage while you are on layoff or an approved leave of absence, you may reenroll within 31 days after the date you return to Active 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, your eligible spouse, and/or eligible children, 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 your eligible spouse and children will terminate on the earlier of:

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

Coverage for your child will terminate on the last day of the calendar month following the month in which he or she ceases to be eligible. However, coverage will be continued beyond the maximum age for an eligible 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 child'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 or replace this coverage.
- Delta Dental decides to terminate this Dental Plan by giving written notice to us 90 days prior to termination.

Your coverage will end if any of the following occurs:

- You use your dental benefits fraudulently or you fraudulently misrepresent or conceal material facts in your application. If this happens, Delta Dental will recover any claim payments made.
- Delta Dental will not pay claims if you or ISU fail to make payment to Delta Dental when due.

### **Authority to Terminate, Amend, or Modify**

ISU has the authority to terminate, amend, or modify the benefits and coverage described in this Summary Plan Description at any time. Any amendment or modification will be in writing. If this Dental Plan is terminated, you may not receive benefits.

### **CONTINUED COVERAGE (COBRA)**

There are some federal and state laws that may affect your dental benefits. These laws apply to continuing your coverage when you are no longer eligible for this Dental Plan.

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

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

- Death of the employee covered under this Dental Plan.
- 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 Dental Plan becomes entitled to Medicare.
- Child/Children are no longer considered eligible by our eligibility rules.
- The employer from whom the covered employee retired files bankruptcy under federal law (in certain cases).

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

If you wish to continue your benefits, you must complete an election form and submit it to us 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 us for the continuation of benefits under this Dental Plan. Depending on how you qualify, you may continue your coverage for up to 18 or 36 months.

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

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

If you lose your coverage, contact us. We will 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 we cease 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.

### **COVERAGE CHANGES EVENTS CHANGING COVERAGE**

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

**Active Duty in the Military** of an eligible child or spouse

**Appointment as a Legal Guardian** of a child

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

**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 of a participant**

**Exhaustion of COBRA Coverage**

**Marriage**

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

**Spouse/Partner or Child Loses Eligibility for Qualifying Dental Coverage** or we cease contributions to qualifying dental coverage. In this case, your eligible spouse/partner and any eligible children previously covered under the prior qualifying dental coverage are eligible for coverage under this Dental Plan.

**Termination of Partnership**

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

*\*Please note:* The eligible spouse or domestic partner and eligible 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 eligible spouse or domestic partner is not eligible for other group coverage. The eligible 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 eligible children may continue to be covered until the earlier of the date the eligible spouse or domestic partner's coverage terminates; or the date the child ceases to qualify as an eligible child.

## **NOTIFICATION OF CHANGE**

You must notify ISU within 31 days of the date of the event that changes the status of your eligibility except birth or adoption of a child. Delta Dental of Iowa must be notified within 60 days of the date of the event that changes your eligibility for births or adoptions. You can ask your employer or group sponsor to help you make this request. If a change to your eligibility is not made within 31 days of an event

(except birth or adoption of a child which is 60 days), the person(s) affected may lose important coverage.

## **COVERAGE TERMINATION EFFECTS OF TERMINATION**

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

- *Delta Dental will not pay* for any services or supplies provided after the date the coverage is terminated.
- This Dental Plan *will retain legal rights*. This includes the right to initiate a civil action based on fraud, concealment, or misrepresentation.

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

## **DELTA DENTAL'S RIGHT TO RECOVER PAYMENTS PAYMENT IN ERROR**

If for any reason Delta Dental makes payment under this Dental Plan in error, Delta Dental may recover the amount Delta Dental paid.

## **SUBROGATION**

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

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

You and your other eligible Covered Person(s) agree to all of the following:

- You will let Delta Dental know about any potential claims or rights of recovery related to the illness or injury;
- You will furnish any information and assistance that Delta Dental determines Delta Dental will need to enforce the Dental Plan's rights;
- You will do nothing to prejudice the Dental Plan's rights and interests;

- You will not compromise, settle, surrender, or release any claim or right of recovery described above, without getting Delta Dental’s written permission;
- You must reimburse Delta Dental to the extent of benefit payments made under this Dental Plan if payment is received from the other party or parties;
- You must notify Delta Dental if you or your beneficiaries have the potential right to receive payment from someone else;
- You must cooperate with Delta Dental to ensure that Delta Dental’s rights to subrogation are protected.

## **OTHER INFORMATION NOTICE**

You may send any notice to the Dental Plan at the following address:

*Delta Dental of Iowa  
P.O. Box 9010  
Johnston, IA 50131-9010*

Any notice from Delta Dental to you is valid when sent to your address as it appears on Delta Dental’s records or the address of the group through which you are enrolled.

You may contact our Claims Administrator at the following address:

*Delta Dental of Iowa  
P.O. Box 9010  
Johnston, IA 50131-9010*

## **NONASSIGNMENT**

Benefits for Covered Services described in this Summary Plan Description are for your personal benefit and cannot be transferred or assigned to anyone else without our consent. Any attempt to assign your rights under this Dental Plan 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 Summary Plan Description 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 Dental Plan 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 Delta Dental because of a claim under this Dental Plan, or because of the alleged breach of the terms of this Dental Plan more than two years after the end of the calendar year in which the services or supplies were provided.

## **INFORMATION IF YOU ARE OR A MEMBER OF YOUR FAMILY IS ENROLLED IN MEDICAID**

### **Assignment of Rights**

This Dental Plan will provide payment of benefits for Covered Services to a participant, 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 Dental Plan, nor will it affect Delta Dental's determination of any benefits paid to you.

### **Acquisition by States of Rights of Third Parties**

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







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

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Toll Free: 1-800-544-0718  
Local: 1-515-261-5500

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