DELTA DENTAL®

Blue Medicare Advantage® – Enhanced PPO
Delta Dental of Iowa

Benefits Certificate

Blue Medicare Advantage® – Enhanced PPO
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Hello!

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

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

For instance, you'll learn:

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

So keep reading. You'll be glad you did. And if you have any questions about your Policy or a claim just give us a call at 833-721-2892, Monday through Friday or email us at MAMembers@deltadentalia.com.

You can easily view your benefits, claims and eligibility information online 24 hours a day, seven days a week by visiting IowaDentalMA.com and selecting the link for our Member Connection.

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

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

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

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

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

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

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Summary of benefits and payment

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

You receive benefits from the categories below:	**From a type of dentist below**	**You pay the Coinsurance percentage below**	**The benefits used count against the Benefit Period Maximum? (Yes/No)**
Benefit Categories	**Type of Network**	**Member Coinsurance***	**Annual Maximum****
	Premier		$2,000
	Non-par		
Check-ups and teeth cleanings (Diagnostic and Preventive)	Premier	0%	No
	Non-par	50%	No
Cavity repair and tooth extractions (Routine and Restorative Services)	Premier	25%	Yes
	Non-par	50%	Yes
Posterior composite(s) (Tooth-colored filling(s) on back teeth)	Premier	25%	Yes
	Non-par	50%	Yes
Root canals (Endodontic Services)	Premier	25%	Yes
	Non-par	50%	Yes
Gum and Bone Disease (Periodontal Services)	Premier	25%	Yes
	Non-par	50%	Yes
Extractions Surgical and non surgical	Premier	25%	Yes
	Non-par	50%	Yes
High-cost restorations (Restorations)	Premier	25%	Yes
	Non-par	50%	Yes
Dentures and bridges (Prosthetics)	Premier	25%	Yes
	Non-par	50%	Yes

*Member Coinsurance is the percent of costs *you pay* each time you receive certain covered services.
**Annual Maximum is the maximum dollar amount *we'll pay* for all Covered Services under the Policy in a Calendar Year.

Important information

Your Delta Dental Medicare Advantage Policy is provided by Wellmark Advantage Health Plan and Delta Dental of Iowa.

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

A big part of this program is our network of dentists. Of course, you can see just about any dentist you want. But there are some pretty big advantages for you—like cost savings—when you see a participating Delta Dental Dentist.

Generally, you'll save the most when you see participating Delta Dental Dentists.

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

What you should know about participating Delta Dental Dentists

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

When you see participating Delta Dental Dentists:

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

What you should know about Non-Participating Dentists

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

When you see Non-Participating Dentists:

- They haven't agreed to accept their Delta Dental Member Company's payment arrangement or any other payment arrangement. They can charge whatever they want.
- You're responsible for any difference between the dentist's Billed Charge and the Delta Dental Non-Participating Dentist fee schedule.
- Many non-network dentists will file your dental claim, but they are not required to file the claim. That means you may need to take care of any paperwork about your claims.
- We settle claims with you, not the Non-Participating Dentist. However, for Iowa Non-Participating Dentists, the payment is made out to you and mailed to you. It is your responsibility to pay your dentist in full. This includes any Member Coinsurance and non-approved charges you may owe.
- They don't agree to handle the Pre-Service Estimate for you. See **Pre-Service Plan Estimate** section for more information.
- Non-Participating Dentist may charge for "infection control." This includes the cost for services

and supplies associated with sterilization procedures. You're responsible for these extra charges. (All dentists are legally required to follow certain infection control guidelines. But participating Delta Dental Dentists incorporate these costs into their normal fees—so they don't charge an extra fee for infection control.)

Keeping an eye on quality and cost

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

Is the procedure Dentally Necessary?
Both of these must be true for the procedure to be Dentally Necessary:

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

Is the procedure Dentally Appropriate?
All of this must be true for the procedure to be Dentally Appropriate:

- The treatment is the most appropriate for your situation and
- The treatment meets professionally recognized standards of dental care, and complies with our clinical criteria and

Do policy limitations apply?
Policy limitations are amounts that are your responsibility based on your Policy with us. Here are some examples:

- Amounts for procedures that aren't dentally necessary or dentally appropriate.
- Amounts for procedures that aren't covered by this Policy.
- Amounts for procedures that have frequency or dollar limits (For example, teeth cleanings are covered twice per Calendar Year. Additional teeth cleaning may not be covered—even if your dentist says it's dentally necessary and dentally appropriate. See Benefits for a description of covered procedures and limitations associated with certain procedures.)
- Amounts for procedures that have reached policy maximums. See the **Summary of Benefits and Payment** charts at the beginning of this Policy.
- Any difference between the dentist's Billed Charge and the applicable fee schedule, or the Maximum Plan Allowance. This only applies:
    - If you receive services from a Non-Participating Dentist, or
    - To procedures that aren't Covered Services, or
    - To Member Coinsurance.

Our payment policy

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

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

Definitions of common payment terms

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

Adverse Benefit Determination
Any denial, reduction or termination of the benefits for which you filed a claim. Or a failure to provide or to make a payment (in whole or part) of the benefits you sought including any such determination based on eligibility, application of any utilization review criteria, or a determination the services which benefits were provided was not medically necessary or appropriate.

Appeal
The procedures that deal with the review of adverse initial determination for payment of services.

Benefit Period
A Benefit Period is the same as a calendar year. It begins on the day your coverage goes into effect and starts over each January 1. We use your Benefit Period to calculate your Deductible and Benefit Period Maximum, if applicable.

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

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

Delta Dental Medicare Advantage Dentist
A Dentist who has signed an agreement with Delta Dental for This Plan that is part of Delta Dental's Medicare Advantage Network.

Dentist
A person licensed to practice dentistry in the state in which the dental service are performed.

Grievance
An expression of dissatisfaction with any aspect of the operation, activities or behavior of Delta Dental, Wellmark Advantage Health Plan or a Dentist that has provided dental services under This Plan.

Maximum Plan Allowance
Maximum Plan Allowance is the amount we establish as the maximum allowable fee for certain Covered Services provided by Premier Panel Dentists.

We establish the Maximum Plan Allowance for dental services contained in the "Current Dental Terminology," book published by the American Dental Association. Several factors are taken into consideration, including but not limited to:

- Contracts with dentists
- The simplicity or complexity of the procedure
- The Billed Charge for the same procedure by dentists in the same geographic area, with similar training and skills
- Leading economic indicators, like the Consumer Price Index

Medicare Advantage Dentist Fee Schedule
The maximum fee allowed per procedure for services rendered by a Delta Dental Medicare Advantage Dentist as determined by Delta Dental.

Member
A person with coverage under This Plan.

Non-Participating Dentist
A Dentist who has not signed an agreement with Delta Dental to become part of the Delta Dental Medicare Advantage Network. Services received from a dentist who does not participate in Delta Dental's Medicare Advantage Network will be processed as services received from a non-participating dentist and your out-of-pocket cost may be higher. IMPORTANT: if you receive services from a dentist that does not participate in Delta Dental's Medicare Advantage Network you will be responsible for the difference between Delta Dental's payment to you and the amount charged by the non-participating dentist.

Policy Effective Date
The Policy Effective Date is the first day of the Wellmark Advantage Health Plan.

Pre-Service Organization Determination
A determination that is made prior to receiving dental services based on your benefits and coverage. This decision will determine whether a dental service will be covered and will provide information on how much you may have to pay for this service. This is a request submitted by you or your Dentist.

Understanding the terms and amounts you pay to share costs.

Member Coinsurance

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

Your coinsurance is calculated based on the applicable fee schedule. In general, your coinsurance percentage depends on the benefit category of the service you receive and the participation status of your dentist.

Annual Maximum

Annual Maximum is the maximum amount we may pay for all Covered Services in a Calendar Year. This amount is shown on the **Summary of Benefits and Payment** charts at the beginning of this Policy, if applicable.

Other payment responsibilities

In addition to the above, you will be responsible for paying dental care charges when Delta Dental does not make any payment because you have not paid your Member Coinsurance, or have exceeded your Calendar Year Maximum, or frequency limitations. This is the case even when a Medicare Advantage Panel Dentist provided the services.

Help when you have questions

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

Benefits

Check-ups and teeth cleaning (Diagnostic and Preventive Services)		
Benefit	Description	Limit (if any)
Dental Cleaning (Prophylaxis)	Removing plaque, tartar (calculus) and stain from teeth and implants.	This procedure is a benefit twice per Calendar Year.
Oral Evaluations	A dental exam that includes checking for cavities, gum disease and any other concerns in the mouth, face, and neck that are related to the oral cavity.	This procedure is a benefit twice per Calendar Year. This includes all dental exams including preventative, comprehensive and consultations.
Topical fluoride applications	Professional administered procedure in which the dental surfaces are coated with a fluoride solution or gel to help prevent decay.	The procedure is a benefit twice per Calendar Year.
Bitewing X-Rays	Shows the crowns of the upper and lower teeth at the same time; held in place by a tab between the teeth.	Only one set of either Bitewing X-Rays or Periapical X-Rays are a benefit once per Calendar Year, but not both. If both Bitewings and Periapical X-Rays are done on the same day by the same dentist, they will be combined and paid as a Full Mouth X-Ray.
Extraoral X-Rays	X-Rays that are made with the film outside the mouth.	One set of Extraoral X-Rays or Occlusal X-Rays are a benefit once per Calendar Year.
Full-Mouth X-Rays	Combination of individual Bitewings and Periapical X-rays taken by a dentist on the same service date.	This procedure is a benefit once every three consecutive years. Note: A panoramic X-ray is a benefit if full-mouth X-rays haven't been done within three (3) years of the panoramic X-ray.
Occlusal X-rays	Capture all upper and lower teeth in one image; the film rests on the biting surface of the teeth.	One set of Extraoral X-Rays or Occlusal X-Rays are a benefit once per Calendar Year.
Periapical X-rays	A radiographic image of a tooth (or some teeth) that shows the crown and root portions.	One occurrence of up to four Bitewing X-Rays and/or up to six Periaplical X-Rays in 12 consecutive months. If both Bitewings and Periapical X-Rays are done on the same day by the same dentist, they may be combined and paid as a Full Mouth X-Ray.

Periodontal-Maintenance Therapy	A dental cleaning that is deeper than a regular cleaning, but for people with a history of periodontal (gum) disease and treatment of that gum disease.	To qualify as covered Periodontal Maintenance Services, maintenance services should follow Non-surgical or Surgical periodontal therapy. When this procedure immediately follows complex or conservative periodontal therapy, this benefit is available: Up to four times per Calendar Year. This procedure takes the place of the dental cleaning benefit (prophylaxis) described under check-ups and teeth cleaning.
Problem Focused Exams	A type of emergency dental exam in which the provider diagnoses a specific acute problem.	This procedure is a benefit twice per Benefit Period.

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

Root Canals (Endodontic Services)		
Benefit	Description	Limit (if any)
Apicoectomy/Periradicular Surgery	Surgery to repair a damaged root of root canal therapy or to correct a previous root	

	canal.	
Direct Pulp Cap	Covering exposed pulp with a dressing or cement to protect it and promote healing and repair.	
Pulpotomy	Removing the coronal portion of the pulp as part of root canal therapy.	
Retrograde Fillings	Sealing the root canal by preparing and filling it from the root end of the tooth.	
Root Canal Therapy	Treating an infected or injured pulp to retain tooth function; generally involves removing the pulp and replacing it with an inert filling material.	

Gum and Bone Diseases (Periodontal Services) Note: Some of these procedures should receive our review before they're performed. To learn more about the review process, see the Pre-Treatment Plan Estimate section.		
Benefit	Description	Limit (if any)
Full Mouth Debridement	Preliminary removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation.	This procedure is a benefit once in a lifetime after 36 months have elapsed since your last dental cleaning (prophylaxis).
Guided Tissue Regeneration	Services and supplies for regeneration of lost periodontal structures.	
Non-Surgical Periodontal Treatment (Root Planing and Scaling)	Deep cleaning procedure to remove dental plaque and calculus for those with gum disease which normally includes loss of the supporting bone structure.	This procedure is a benefit once every 24 months for each quadrant of the mouth.
Surgical Periodontal Procedures	Various surgical interventions designed to repair and regenerate gum and bone tissues that support the teeth.	This procedure is a benefit once every 36 months for each tooth or quadrant of the mouth for natural teeth only. Note: a quadrant is one of the four equal sections of the mouth into which the jaws can be divided; it includes four or more teeth or bounded (contiguous) teeth spaces in a row.

High-Cost Restorations (Restorations) Note: The procedures in this category should be reviewed by us before they're performed. To learn more, see the Pre-Treatment Plan Estimate section.		
Benefit	Description	Limit (if any)
Restorations for complicated tooth decay or fracture	Restoring a tooth with a different type of filing (i.e. cast) when the tooth cannot be restored with a silver (amalgam) or tooth-colored (composite) filling.	This procedure is a benefit once every (5) five years, beginning from the date the restoration is cemented in place.
Crowns	Restoring form and function by covering and replacing the visible part of the tooth with a precious metal, porcelain fused to metal or a porcelain crown.	Crowns are a benefit only if the tooth can't be restored with a routine filling; Crowns are a benefit once every (5) five years, beginning from the date the restoration is cemented in place. Crowns placed mainly for periodontal splinting, cosmetics, altering vertical dimension, restoring your bite (occlusion) or restoring a tooth due to attrition, abrasion, erosion, and abfraction are not a benefit.
Posts and cores	Preparing a tooth for a crown after a root canal to strengthen the tooth.	This procedure is a benefit once every (5) five years, beginning from the date the restoration is completed.
Recementation of Restorations	Recementation of an inlay, onlay, or crown that has become loose.	This procedure is a benefit once every 12 months—after (6) six months have elapsed since initial placement.

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

Services Not Covered (Policy Exclusions)

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

Treatment, Service or Supplies:	What's NOT covered (Excluded) - You are not covered for:
Anesthesia or analgesia	You are not covered for intravenous sedation, local anesthesia, non-intravenous conscious sedation or nitrous oxide (relative analgesia).
Athletic Mouth Guard	You are not covered for resilient intraoral devices worn during participation in contact sports that reduce the potential for injury to the teeth and associated tissue.
Broken appointments	Fees charged by your dental office because of broken appointments.
Complete occlusal adjustment	Services or supplies used to revise or alter the functional relationships between upper and lower teeth.
Complications of a non-covered procedure	Costs related to dental problems that result from a non-covered procedure.
Congenital deformities	Services or supplies to fix congenital deformities, such as cleft palate.
Cosmetic in nature	Services or supplies that are mainly to improve the appearance of your teeth rather than restoring or improving dental form and function of natural teeth.
Desensitizing medicament or resin	The application of desensitizing medicament or resin for cervical and/or root surface sensitivity either on a per tooth or per visit basis.
Drugs	Prescription or non-prescription drugs or medications.
Effective date	Services or supplies received before the Policy Effective Date of coverage under this Policy.
Experimental or Investigative	Services or supplies that are considered experimental, investigative or have a poor prognosis. We will use Peer-reviewed outcomes data from clinical trials, Food and Drug Administration regulatory status, and established governmental and professional guidelines to make this determination.
Incomplete services	Dental services that haven't been completed.
Indirect pulp caps	Indirect pulp caps are not covered.
Infection control	Separate charges for "infection control." This includes the costs for services and supplies for sterilization procedures and personal protective equipment. Delta Dental Dentists include these costs into their normal fees.
Inlays	Inlays are not covered.
Limited Occlusal Adjustment	There is no coverage for the reshaping of biting surfaces of one or more teeth.
Lost or stolen appliances	Services or supplies to replace lost or stolen dental appliances.
Medical services or supplies	Services or supplies that are medical in nature, including, but not limited to: Dental services performed in a hospital Treatment of fractures and dislocations

	Treatment of cysts and malignancies Accidental injuries
Military service	Services or supplies needed to treat an illness or injury received while you're on active status in the military services. However, if you ask in writing, you may get a refund of premiums you paid while on active military status.
Onlays	Onlays are not covered.
Payment responsibility	Services or supplies when: Someone else has the legal obligation to pay for your care; and, When you wouldn't be charged if you did not have this Policy.
Periodontal appliances	You are not covered for services or supplies for periodontal appliances (bite guards) to reduce bite (occlusal) trauma due to tooth grinding or jaw clenching.
Periodontal splinting	Services or supplies used mainly for reducing tooth mobility, including crown-type restorations.
Plaque-control programs, oral hygiene instructions and dietary instructions	Services or supplies for plaque control, oral hygiene and/or dietary instructions are not covered.
Policy termination	Any treatment received after the coverage termination date of this Policy.
Provisional crowns, bridges or dentures	Services or supplies for provisional crowns, bridges or dentures are not covered.
Repair, replacement or duplication of orthodontic appliances	Services or supplies needed to fix, replace or duplicate any orthodontic appliance are not covered.
Sales tax and fees	We do not pay sales tax or fees billed by dentists for dental services.
Sealants	There is no coverage for sealants or preventive resin applications.
Services not paid to some extent by us	Services that would otherwise qualify as a Covered Service, but Delta Dental does not make a payment to some extent. This may include services not paid because of your need to satisfy applicable Member Coinsurance, Calendar Year Maximums, and/or frequency limitations.
Services not provided in a dental office setting	Services not provided in a dental office setting.
Space Maintainers	You are not covered for space maintainers or the removal of fixed space maintainers.
Specialized services	Specialized, personalized, elective materials and techniques or technology that aren't reasonably needed for the diagnosis or treatment of dental disease or dysfunction. Specialized services are enhancements to other services and are considered optional.
Stainless Steel Crowns	There is no coverage for stainless steel crowns.
Straighter teeth - Corrective orthodontics	Corrective Orthodontic services or other procedures directly associated with orthodontics that move teeth to correct an abnormal dental relationship between and among teeth are not covered.
Temporary or interim procedures	Temporary or interim procedures are not covered.
Temporomandibular joint dysfunction (TMD)	Costs for diagnostic x-rays, appliances, restorations or surgery for TMD or myofunctional therapy are not covered.

Treatment by a non-licensed dentist or non-licensed physician	Services or treatment performed by anyone but a licensed dentist, licensed physician, or their employees. Covered Services provided in states where other types of dental providers can practice independently are allowed.
Treatment in Progress	You may not be covered for services or supplies related to treatment which began prior to the effective date of this Policy.
Unerupted teeth	Prophylactic removal of unerupted teeth (asymptomatic and nonpathological). Meaning, the removal of any unerupted tooth that aren't visible or isn't causing harm is not covered.
Workers' compensation	Services or supplies that are or could have been paid under a Worker's Compensation laws, including those applied toward any Deductible under your employer's Worker's Compensation coverage.

Pre-Service Plan Process

Your dentist can submit a request for coverage decision to determine whether you qualify for a dental service that may be covered under This Plan. You may also request a coverage decision to determine whether you qualify for a dental service that may be covered by This Plan by calling the Customer Services department at 833-721-2892 or in writing:

Delta Dental of Iowa
PO Box 9040
Johnston, IA 50131

For a standard coverage decision, Delta Dental will provide an answer within 14 calendar days after receiving your request. To file a fast coverage the standard deadlines must potentially cause serious harm to your health or hurt your ability to function. If Delta Dental approved the fast request, an answer will be provided withing 72 hours. For both standard and fast request, Delta Dental my take up to 14 additional calendar days under certain circumstances. If additional time is taken, Delta Dental will notify you in writing and explain the reasons for the extension.

If Delta Dental does not approve your standard or fast coverage request, you have the right to file an appeal. Please see the Appeal section for more information. Availability of dental benefits at the time your request is completed is dependent on several factors. These factors include, but are not limited to, medical necessity, your continued eligibility for benefits, your available annual maximum benefits, any coordination of benefits, the status of your Dentist, This Plan's limitations, and any other provisions, together with any additional information or changes to your dental treatment. To determine whether a service may be covered under This Plan, review the benefits included in this document.

Filing claims

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

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

Many non-network dentists will file your dental claim, but they are not required to file the claim. That means you may need to take care of any paperwork about your claims.

When to file a claim

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

Make sure the claim is filed promptly after the procedure is done. All claims for Benefits must be filed with Delta Dental within one year of the dates the services were completed.

If you need a claim form or have questions, please call us at 833-721-2892 or visit MAMembers@deltadentalia.com.

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

Delta Dental of Iowa
P.O. Box 9040
Johnston, IA 50131-9000

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

Coordination of Benefits

The coordination of benefits (COB) provision applies when a Person has health care coverage under more than one plan. The order of the benefit determination rule governs the order in which each Plan will pay a claim for benefits. The plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefit it pays so that payment from all Plans does not exceed 100 percent of the total allowable expenses.
Definition:
Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provider coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among the separate contracts.

1. Plan includes: group and non-group insurance contracts, medical care components of long-term care contract, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage, school accident type coverage; benefits for non- medical components of long-term care policies; Medicare supplement policies or coverage under other federal governmental plans that do not permit coordination.

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

This Plan, for the purposes of this section, means the part of the contract providing the health care benefits to which the COB provision applies, and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only

with similar benefits, and may apply another COB provision to coordinate other benefits.

Order of Benefit Determination Rules determines whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan.
When This Plan is primary, it determines payment for its Benefits first before those of any other Plan without considering any others Plan's Benefit. When This Plan is secondary, it determines its Benefits after those of another Plan may reduce the Benefits it pays so that the total benefits paid by all Plan do not exceed the Submitted Amount. In no event will This Plan's payment exceed the Maximum Approved Fees.

Order of Benefit Determination Rules
When a member is covered by two or more Plans, the rules for determining the order of benefit payment are as follows:

1. This Plan will pay primary over any Medicaid or Retiree Plan that you may have.
2. This Plan will pay secondary to any employer sponsored, automobile, group or individual Plan you may have, except for those listed in (1) above.
3. If this Plan is the Primary Plan, it will pay its benefits according to the terms of coverage and without regard to any other Plan coverage.
4. Except as provided in the following paragraph, a Plan that does not contain a COB provision is always primary unless otherwise required by law.
5. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Coordination Disputes
If you believe we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. You or your dentist should contact Delta Dental's Customer Service department and ask them to check the claim to make sure it was processed correctly. You can do this by calling 1-833-721-2892 and speaking to a customer service representative. You may also refer to the Grievance and Appeals section below.

You have the right to appeal our decision

You have the right to ask Delta Dental to review our decision by asking us for an appeal.

Plan Appeal: Ask Delta Dental for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for an appeal with Delta Dental" for information on how to ask for a plan level appeal.

If you want someone else to act for you

You can name a relative, friend, attorney, provider, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-833-721-2892 to learn how to name your representative. TTY users call 711. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

There are 2 kinds of appeals with Delta Dental

Standard Appeal - We'll give you a written decision on a standard appeal within **30 days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a medical service/item you've already received, we'll give you a written decision within **60 days.**

Fast Appeal - We'll give you a decision on a fast appeal within **72 hours** after we get your appeal. You

can ask for a fast appeal if you or your provider believe your health could be seriously harmed by waiting up to 30 days for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a medical service/item you've already received.

We'll automatically give you a fast appeal if a provider asks for one for you or if your provider supports your request. If you ask for a fast appeal without support from a provider, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 days.

How to ask for an appeal with Delta Dental

Step 1: You, your representative, or your provider must ask us for an appeal. Your written request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Whether you want a Standard or Fast Appeal (for a Fast Appeal, explain why you need one)
- Any evidence you want us to review, such as medical records, providers' letters (such as a provider's supporting statement if you request a fast appeal), or other information that explains why you need the medical service/item. Call your provider if you need this information.

If you're asking for an appeal and missed the deadline, you may ask for an extension and should include your reason for being late.

We recommend keeping a copy of everything you send us for your records. You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

Step 2: Mail, email, or deliver your appeal.

For a Standard Appeal:

Mailing Address:
Delta Dental of Iowa
P.O. Box 9040
Johnston, IA 50131-9000

Phone:
1-833-721-2892

Hearing Impaired Toll Free:
1-888-287-7312

Email:
MAMembers@deltadentalia.com

For a Fast Appeal:
Phone:
1-833-721-2892
Hearing Impaired Toll Free:
1-888-287-7312
Email:
MAMembers@deltadentalia.com

What happens next?

If you ask for an appeal and we continue to deny your request for payment of a medical service/item, we'll automatically send your case to an independent reviewer. **If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.**

Your Policy

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, this Policy, and any riders or amendments.

All of the statements made by you in any of these materials will be treated by us as representations to us, upon which we may rely. We will not use the statements to deny any claim unless we have furnished you with a copy of the statement.

Eligibility enrollment requirements

To be eligible for this Policy:

- You must be a permanent Iowa resident.
- You must select a Medicare Advantage plan with coverage through Wellmark.

When coverage begins

Your coverage under this Policy starts on your Policy Effective Date. Before you receive benefits under this Policy, you must allow any healthcare provider to give us information about a treatment or condition for which we are being billed. If we don't get the information requested (or if you withhold information in your application), you may not get coverage and benefits may be denied.

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

When coverage ends

Your Delta Dental Coverage may automatically terminate:

1. When Wellmark Advantage Health Plan advises Delta Dental to terminate your coverage.
2. On the first day of the month for which Wellmark Advantage Health Plan has failed to pay Delta Dental.
3. For fraud or misrepresentation in the submission of any claim.
4. For any other reason stated in the contract between Delta Dental and Wellmark Advantage Health Plan.
5. Delta Dental will not continue eligibility for any person covered under This Plan beyond the termination date requested by Wellmark Advantage Health Plan. A person whose eligibly is terminated may not continue coverage under this Certificate.

Our right to recover payments

Payment in Error

If for any reason we make payment under this Policy in error, we may recover the amount we paid.

Subrogation

Once you receive benefits under this Policy due to an illness or injury, we'll assume any legal right you

have to collect any payment related to the illness or injury. That includes benefits from:

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

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

- Let us know about any potential claims or rights of recovery related to the illness or injury.
- Give us any information or help we need to enforce our rights under this Policy.
- Not do anything to prejudice our rights and interests.
- Not compromise, settle, surrender or release any claim or right of recovery described above without our written permission.
- Reimburse us for benefit payments made under this Policy, if you get paid from the other party.
- Let us know if you may have the right to receive payment from someone else.
- Cooperate with us to make sure our rights to subrogation are protected.

Other information notice

You can send any notice to our home office:

Delta Dental of Iowa
P.O. Box 9040
Johnston, IA 50131-9010

Any notice from us to you is valid when sent to the address we have for you in our records.

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

Governing law
This Policy will be interpreted in accordance with and governed by the laws of the state of Iowa, unless any federal laws supersede state laws. Any action brought because of a claim under this Policy willbe litigated exclusively in the state or federal courts located in the state of Iowa and in no other.

Legal action
No legal or equitable action may be brought against us because of a claim under this Policy, or because of the alleged breach of this Policy, more than two years after the end of the calendar year in which the services or supplies were provided.

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

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

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

Delta Dental of Iowa complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. To review our full nondiscrimination notice go to www.deltadentalia.com/nondiscrimination.

Delta Dental of Iowa

P.O. Box 9040

Johnston, IA 50131-9000

Hearing Impaired Toll Free: 1-888-287-7312
Toll Free: 1-833-721-2892
Local: 1-515-261-5500

www.IowaDentalMA.com
MAMembers@deltadentalia.com
Claims@deltadentalia.com