DELTA DENTAL PLAN
OF IOWA

Statewide Service Network Offices

Ames-50010
Southgate Square
2515 Elwood Drive
Suite 107
515/292-7201

Burlington-52601
Roosevelt Place
1000 North Roosevelt
319/752-3697

Cedar Rapids–52401
1660 42nd St., N.E.
319/366-5348

Davenport–52807
2322 East Kimberly Road
Suite 120W
319/359-3406

Dubuque-52001-6868
One Cycare Plaza
Suite 170
319/588-2033

Iowa City-52240
1901 Broadway Street
319/351-7656

Marshalltown-50158
2nd and Linn
515/752-4661

Mason City-50401
1410 6th Street, S.W.
P.O. Box 1585
515/424-3162

Newton-50208
425 1st Avenue, East
P.O. Box 766
515/792-5029

Ottumwa-52501
625 East Pennsylvania Ave.
P.O. Box 577
515/682-7523

Red Oak-51566
109A Oak Street
712/623-5444

Sioux City-51102
Hamilton Blvd. & I-29
P.O. Box 1677
712/277-3081

Waterloo-50704
3602 Kimball Avenue
P.O. Box 1827
319/235-7037

MAIN OFFICE
Des Moines-50309
636 Grand Avenue
515/282-7315

Microware System Corporation

GROUP DENTAL CARE PLAN

DELTA DENTAL PLAN
OF IOWA

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INTRODUCTION

Prepaid dental care is different than health insurance. Most insurance is designed to protect you if illness or injury occurs. Delta Dental Plan of Iowa is different because it is designed to protect you from things going wrong, and to help you pay for things that do. Your Delta Dental Plan of Iowa coverage is designed to be used. This policy pays for a sound preventive care program that should ensure that you have a lifetime of healthy teeth.

To use it, all you need to do is:

1. Select a dentist that is a **MEMBER** of Delta Dental Plan of Iowa. That's the way to get the maximum value from your Delta Dental coverage. Delta Dental of Iowa will pay other dentists but we can not protect you from additional costs if they charge more than the payment levels which **MEMBER** Delta Dental dentists have agreed to accept. For the purposes of this booklet, participating Delta Dental dentists will be referred to as **MEMBERS.**

2. Talk to your dentist about the condition of your mouth. Select a check-up schedule that will get you healthy and keep you healthy. Not everyone needs to visit the dentist twice a year and some may need to go more often.

Delta Dental Plan of Iowa believes that dental care can, and should be, affordable. This program is designed to cover most of your dental needs. But there are some features that were designed to limit excessive cost. Delta wants you to have a good dental health program at an affordable price. Use your Delta Dental Plan of Iowa wisely.

Which Services Are Covered and Which Are Not

All of the procedures paid for by Delta Dental Plan of Iowa are procedures which have been proven to restore or maintain your teeth and the bone and gums which support your teeth. The emphasis is on prevention. It's better to maintain your teeth than it is to repair them. And, it's better to do small repairs than it is to do big ones.

1. Annual Maximum Payable

$1,500 per member coverage per calendar year.
$1,000 per individual per lifetime for orthodontic benefits.

2. Deductible*

Single: $25.00 per calendar year.
Family: $75.00 per family per calendar year.
(THERE IS NO DEDUCTIBLE FOR PARAGRAPH A).

B. **LEGISLATION FOR DISABLED INDIVIDUALS (Omnibus Budget Reconciliation Act of 1986) (Generally applicable to employers with 100 or more employees)**

Medicare benefits are secondary for health services provided to a disabled Medicare beneficiary, under age 65, who has health coverage through a "large group health plan" by reason of their employment or the employment of a family member. A "large group health plan" is generally defined as a plan that covers employees of at least one employer of 100 or more employees.

III. **CONTINUATION UNDER IOWA LAW (Generally applicable to employers and group sponsors with less than 20 employees)**

Chapter 509B, Iowa Code, entitles you and your eligible dependents to continue benefits under this plan if you have been continuously covered for three months prior to loss of coverage due to termination of employment or association membership. An employer or group sponsor who offers continuation rights under COBRA shall be deemed to comply with the requirements of Chapter 509B.

Consult your employer or group sponsor if your employment or membership is terminated. Your employer or group sponsor must provide you with written notice of your right to Iowa continuation coverage within ten (10) days of your termination of employment or membership. If you desire Iowa continuation coverage, your written request for continuation must be returned to your employer or group sponsor within ten (10) days following the later of: (1) the date of your termination; or (2) the date you are given notice of your right to Iowa continuation coverage by your employer or group sponsor. If your employer or group sponsor gives you proper notice of your Iowa continuation rights, you or your dependents are not eligible to elect Iowa continuation more than thirty-one (31) days after the date of termination.

In the event of dissolution or annulment of marriage or your or your eligible dependents' death, the individual eligible for continuation, i.e., your spouse or eligible dependents, must notify your employer or group sponsor within 30 days after such event.

The maximum continuation of coverage under Iowa law is nine (9) months and may not include every benefit available to active employees or association members. You or your eligible dependents will be responsible for paying the applicable premium for Iowa continuation coverage.

Order of payment: Biological parent with earlier birth month/day.
Spouse of parent with earlier birthday.
Biological parent with later birth month/day.
Spouse of parent with later birthday.

6. If none of the above rules applies, the group contract with the earliest continuous effective date is prime.

STATE AND FEDERAL LAWS AFFECTING COVERAGE

I. **CONTINUATION UNDER FEDERAL COBRA LAW (Applicable to employers and group sponsors with 20 or more employees)**

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides that, in the event your employer or group sponsor employs 20 or more individuals, you and your eligible dependents are entitled to continuation of coverage under this health care plan if coverage is lost due to one of the following qualifying events: (1) death of the employee covered under this plan; (2) termination (for other than gross misconduct) or reduction of hours of the eligible employee; (3) dissolution of marriage or legal separation of the eligible employee from the employee's spouse; (4) the eligible employee becomes eligible for Medicare; (5) dependent children cease dependent status under this plan; (6) certain individuals receiving medical benefits from employer involved in a Chapter 11 bankruptcy proceeding.

You or your eligible dependents have the responsibility to notify your employer or group sponsor of a dissolution of marriage, legal separation, or a child losing dependent status.

You or your eligible dependents will have sixty (60) days from the date coverage is lost or are notified of the right to elect COBRA continuation coverage, whichever is later, to inform your employer or group sponsor that COBRA continuation coverage is desired. The maximum continuation of coverage under COBRA is 18 or 36 months, depending upon the qualifying event. You or your eligible dependents will be responsible for paying the applicable premium for COBRA continuation coverage.

Extension of Coverage for Disabled Individuals:
Qualified beneficiaries who are determined to be disabled under the Social Security Act at the time they become eligible for COBRA continuation coverage are entitled to coverage for up to 29 months.

II. **MEDICARE SECONDARY PAYOR LEGISLATION**

A. **WORKING AGED LEGISLATION (Tax Equity and Fiscal Responsibility Act of 1982 and related amendments) (Applicable to employers with 20 or more employees)**

This legislation requires that affected employers provide their active employees and spouses of active employees age 65 or older the opportunity to elect as primary coverage either the employer group health benefit plan or Medicare. Medicare benefits are secondary to benefits available under the employer group health plan for active employees and spouses of active employees age 65 or older.

BENEFITS

A. Diagnostic and Preventive Services

80% of UCR Paid

1) Routine periodic oral examinations at six (6) consecutive month intervals.
2) Bitewing, periapical, occlusal and extraoral x-rays, each at twelve (12) consecutive month intervals, unless more frequent x-rays are dentally necessary.
3) Full mouth x-rays in any five (5) year interval, unless more frequent x-rays are dentally necessary.
4) Dental prophylaxis as prescribed by the dentist, but not more than once in any six (6) month interval.
5) Topical flouride applications for unmarried dependent children, as prescribed by the dentist, but not more than once in any twelve (12) month interval.

B. Routine and Restorative Services

50% of UCR Paid

1) Emergency treatment for relief of pain.
2) Restoration of teeth, as the result of decay or fracture; amalgam, and synthetic porcelain restorations, composite, and plastic restorations.
3) Routine oral surgery, provides for tooth removal which includes pre and post operative care and local anesthetic; also alveoplasty (removal and replacement of bone adjoining teeth) only when performed in conjunction with removal of the tooth.
4) Space maintainers for missing posterior teeth, where indicated but only for unmarried dependent children less than age 14.
5) **Topical application of sealants for unmarried dependent children who are less than 15. No more than a single application for each molar. Lifetime maximum per member of $120.00.**
6) Palliative treatment, if furnished with an accompanying x-ray at the time of service.
7) General anesthesia (intravenous sedation) in conjunction with oral surgery when billed by the operating dentist.

C. Endodontics and Conservative Periodontics

50% of UCR Paid

1) Endodontics, pulp cap, pulpotomy, root canal therapy, apical curettage, root sections, hemisection, apicoectomy and retrograde filling.

Limitations:

a. A retrograde filling, as initial treatment, would be considered a benefit in lieu of a root canal.

b. Apicoectomy and retrograde fillings are covered as separate benefits only if a year had elapsed since the root canal therapy.

2) **Conservative periodontics*:** procedures necessary for the treatment of the diseases of the gingiva (gums).

Limitations: Periodontal scaling and root planing once in a 24 month period. Curretage is covered only when performed as part of the root planing procedure.

***NOTE: Conservative periodontic procedures require prior approval by Delta Dental (the dentist must submit a proposed treatment plan before beginning treatment.)**

D. Other Major Restorative Procedures

50% of UCR Paid

1) Special restorative services, required as the result of tooth decay or fracture, including cast restorations, porcelain inlays, porcelain crowns, subject to the following limitations:

a) **Cast restorations*** — are covered only if a tooth cannot be restored by use of a silver or composite filling. Cast restorations will be replaced only if five years have elapsed since the previous placement.

b) **Crowns*** — are covered only if a tooth cannot be restored by a filling and will be replaced only if five years have elapsed since the last placement of the crown. Crowns placed for the primary purpose of periodontal splinting, altering vertical dimension or restoring occlusion are not a contractual benefit.

***NOTE: All cast restorations or crowns require prior approval by Delta Dental (the dentist must submit a proposed treatment plan before beginning treatment.)**

2) **Prosthetics—Removable and Fixed**

50% of UCR Paid

a) Bridges, partial dentures and complete dentures for the replacement of fully extracted or missing permanent teeth.
b) Repairs to bridges and full or partial dentures.
c) Relining dentures, but only if relining is performed more than one year after initial installation of dentures and then only one per two-year period.
d) Recementing bridges, inlays, crowns and space maintainers.
e) Adding additional teeth to partial dentures.

Limitation: A prosthetic appliance, including immediate dentures, acquired for the purpose of replacing an existing prosthetic appliance will be covered only after five (5) years have elapsed from when last provided by Delta.

The first of the following rules that applies determines your primary carrier:

1. If both coverages are group * but one has coordination of benefits and one does not, the coverage without coordination of benefits is primary.
   *You are enrolled in group coverage when you get your dental coverage through your employer or because of membership in or connection with a particular organization.

2. The coverage which covers the patient as an employee or subscriber is primary over one which covers him/her as a dependent spouse or child.

3. A contract for an actively employed subscriber pays before a retiree or otherwise inactive contract for that same subscriber.

4. In the case of a dependent child, the parent whose birthday occurs first in a calendar year is primary.

   NOTE: If another carrier does not use this rule, then the father's coverage pays before the mother's.

5. When a dependent child is covered by separated or divorced parents, the following rules apply:

   a. If a court decree stipulates which parent has financial or dental insurance responsibility, the parent is prime.

      Order of payment: Court decreed parent.
      Other biological parent.
      Spouse of decreed parent.
      Spouse of other biological parent.

      1. Sometimes the "new" spouse of the court decreed parent will fulfill that parent's obligation by carrying family coverage. In that case, the order of payment is:

         a) Spouse of decreed parent.
         b) Other biological parent.
         c) Spouse of other parent.

   b. If a court decree does not stipulate, then the parent with custody is prime.

      Order of payment: Custodial parent.
      Spouse of custodial parent.
      Other parent.
      Spouse of other parent.

   c. If there is true joint custody—that is, neither biological parent has primary physical custody of the child(ren)—then the parent whose birthday occurs first in a calendar year is prime.

3. **Dental Necessity**

"Dentally Necessary" means services and supplies furnished to the subscriber, or member, if covered by this contract, when and to the extent that they satisfy each of the following:

a. They are dentally required and dentally appropriate for the treatment or maintenance of the teeth and the gums, bone, and other tissues which support the teeth;

b. They follow professionally recognized standards of dental care;

c. Their costs are not excessive when compared with other services that would be equally effective for the treatment or maintenance of the teeth and their supporting structures within the parameters of the contract.

d. **The fact that a dentist may prescribe, order, recommend, or approve certain services for the subscriber or member, if covered by this contract, does not necessarily mean that such services satisfy a, b, and c above.**

Services and supplies which are deemed not dentally necessary include, but are not limited to, the following:

a) The application of laminates, veneers, replacement of amalgam fillings, or any other procedure that is done for reasons of personal appearance or, for unvalidated health reasons;

b) A course of treatment that is deemed not to be professionally acceptable;

c) A course of treatment that chooses a more expensive procedure than that which is necessary to restore the mouth to a professionally recognized standard of oral health.

BENEFIT REVIEW OF SELECTED PROCEDURES

To help keep the cost of dental coverage affordable now and in the future, we have developed an improved benefit review program. Through the benefit review process, Delta Dental professionals review proposed dental treatment plans. If appropriate, Delta Dental will recommend alternative treatments that produce comparable results. These treatments remain consistent with quality dental care, but are less costly. This program is designed to help you make the best decisions when faced with costly dental procedures. The program can save you significant out-of-pocket expenses. And it ensures that you will receive an optimal level of treatment.

Intention of placing a crown will be reviewed to ensure that there is not sufficient supporting structure of the tooth to allow restoration by another filling material.

Conservative periodontic treatment will be reviewed to ensure that the condition of the mouth warrants the level of the treatment recommended by the dentist.

Date: _____

I hereby designate _____ to represent me in the
(Print Name)

appeal of my claim denied by the Delta Dental Plan of Iowa.

_____
(Print Name)

_____
(Signature)

_____
(Claim Number, Date of Service)

3. Delta Dental cannot accept telephone or other oral requests for review. Your request must be in writing and in a separate letter.

4. A request for review should be directed to the Delta Dental Plan of Iowa, Attention: ERISA Review Officer, Station 14, 636 Grand Avenue, Des Moines, Iowa 50309. The ERISA Review Officer has not had any prior involvement with your claim.

5. After a request for review has been received by Delta Dental, you or your designated representative may do one or all of the following:
   a. submit issues and comments in writing within thirty (30) days after Delta Dental has received your request for review.
   b. furnish any additional medical records or documentation that you believe to be relevant to your claim.
   c. review documents pertinent to the denial of your claim during regular business hours (8:00 A.M. to 4:30 P.M., Monday through Friday.)

6. In the event you wish to review sensitive medical records, it will first be necessary for your personal physician to determine whether disclosure of such records would be detrimental to you.

7. Delta Dental will make a final written decision concerning your claim within thirty (30) days after the date request for review was received. However, if special circumstances indicate that more time is needed to properly conduct the review, Delta Dental must send a notice to you or your designated representative advising you of this fact. An extension of time cannot exceed another sixty (60) days. In other words, Delta Dental must furnish you or your designated representative a written decision no later than ninety (90) days after receipt of your request for review of the claim.

8. The review decision will specify the reason for the decision and contain references to pertinent plan provisions (certificate or master contract) on which the decision is based.

IF YOU HAVE ANY QUESTIONS ABOUT THE CLAIMS PROCEDURES OR THE APPEAL PROCEDURE, WRITE TO THE DELTA DENTAL PLAN OF IOWA, ATTENTION: SUBSCRIBER SERVICE, 636 GRAND AVENUE, DES MOINES, IOWA 50309.

SINGLE/FAMILY COVERAGE CHANGES

Changes between single and family coverage or addition of family members to an existing family contract must be made by completing an application form within 30 calendar days of one of the following events:

- Marriage
- Birth or adoption of a child
- Assumption of responsibility for a stepchild or foster child
- Divorce, annulment or dissolution of marriage; legal separation.
- Death of spouse or dependent
- Dependent no longer eligible (age 19 or over, no longer full-time student, dependent marries)
- Employee, spouse or dependent becomes eligible for Medicare
- Employee or spouse reaches age 65

NOTE: When an event occurs you may only add those family members directly affected by the event (not necessarily all family members). For example, birth only entitles you to add the new child, not your spouse or other dependents. A spouse's involuntary loss of other Delta Dental group coverage only entitles you to add your spouse and any other dependents who were covered under your spouse's contract.

CHANGES FROM FAMILY TO SINGLE COVERAGE CAN BE MADE AT ANY TIME. See your Personnel Office for application forms.

WHO CAN BE COVERED UNDER FAMILY COVERAGE?

The employee, employee's spouse, unmarried dependent children to age 19, unmarried full-time students regardless of age. Children totally and permanently disabled prior to age 19 and continuously covered on a Delta Dental contract are covered regardless of age.

ADDRESS CHANGES AND OTHER CHANGES

Delta Dental must have current information in order to process your claims properly and promptly. It is your responsibility to notify your insurance or personnel representative and complete a new application or subscriber change form within thirty (30) days of the following occurrences:

- Address change
- Spouse employed and enrolled in another group coverage

TERMINATION OF COVERAGE

Your coverage will terminate on the last day of the month during which you cease employment. Your coverage will also be terminated immediately for fraudulent use of your coverage.

Coordination of Benefits

If you have other dental coverage programs that duplicate benefits provided by this contract, Delta Dental Plan of Iowa will coordinate benefits with other carriers and with any other Delta Dental Plan of Iowa contract. Coordination of benefits allows the total payment between all coverages to be up to—but not exceed—100% of the cost of the hospital and doctor bills and other covered services.

3) **Complex Periodontics*:**

50% of UCR Paid

Procedures necessary for the treatment of diseases of the gingiva (gums) and the hard and soft tissue supporting the teeth.

Limitation: Only one procedure consisting of gingival surgery, gingival curettage, ossesous surgery or ossesous grafts will be covered for each quadrant of the mouth in a Benefit Period.

***NOTE: Complex Periodontic procedures require prior approval by Delta Dental (the dentist must submit a proposed treatment plan before beginning treatment.)**

E. Orthodontics.

50% of UCR Paid

Services and supplies required for the proper alignment of teeth.

Limitation: Orthodontics are covered only for Unmarried Dependent Children less than age nineteen (19).

COST CONTAINMENT CONTRACT PROVISIONS

1. Alternate Benefits

In all cases in which there are optional techniques of treatment consistent with good dental practice, but carrying different fees, the Plan shall be liable only for the treatment carrying the lesser fee. The Plan's response to a treatment plan will indicate the procedures for which the Plan will make payment and the level of payment to be allowed by the Plan.

2. Benefit Review (Prior Approval)

a. Mandatory

Benefit Review requires that certain designated dental procedures receive a review by Delta Dental professionals before the procedures are performed (see Benefit Review section, page 6.) Radiographs and supportive materials will be reviewed by Delta. The recommendation of your dentist will be accepted or an alternate treatment plan will be approved. Delta will limit its financial liability to U.C.R. payment, minus deductible and coinsurance for the approved treatment. This policy is not a restriction in benefit, but only in Delta's financial liability. It does not preclude the patient and the dentist from selecting the more expensive course of treatment and the patient paying the difference in cost.

b. Optional

Subscribers may request benefit review of any treatment plan in order to determine their liability.

DENTISTS' REASONABLE CHARGE means an amount which may be more or less than the amount determined as the Dentists' Customary Charge or Dentists' Usual Charge if special consideration is required because of the simplicity or complexity of treatment or because there is not sufficient data to support Delta's standard method of determining the Dentists' Customary Charge or Dentists' Usual Charge.

DENTISTS' USUAL CHARGE means the amount billed by a particular Dentist on a claim for a particular service.

IMPORTANT NOTE:

Dentists who are current members of the Delta Dental Plan of Iowa have agreed to accept 100% of the Usual, Customary and Reasonable (UCR) fee as payment in full for dental services provided, subject to any deductible and coinsurance amounts and contract maximums (See page 1.) Delta Dental will reimburse **MEMBER** dentists for covered services, so you have no claim filing problems and no tedious record-keeping.

If you receive services from a dentist who is not a member of the Delta Dental Plan of Iowa, you, the patient will be reimbursed at 100% of the Usual, Customary and Reasonable fee, subject to any deductible and coinsurance amounts and contract maximums. Your dentist may charge you for the difference between the UCR payment and his/her normal charge.

We adjust these usual, customary, and reasonable maximums each year in order to show what dentists actually are charging where you live, not in some faraway city.

If your dentist charges less, we will allow his charge. If your dentist charges more, we will allow only our UCR maximum.

Of course, if you are responsible for paying deductible or coinsurance for a procedure, we would subtract those from our allowance to the dentist.

HOW TO FILE A CLAIM

Your claims for benefits must be submitted to Delta Dental Plan of Iowa within 365 days of the end of the benefit period in which the claim was made.

MEMBER Delta Dental Plan Dentist (over 85% of Iowa's Dentists are **MEMBERS**.)

Present your Delta Dental I.D. card to the Dentist. The Dentist will file the claim for you and Delta Dental will reimburse the Dentist directly.

Non-MEMBER Dentist: Most non-**MEMBER** Dentists in Iowa will file your claim for you. If your Dentist does not want to file your claim, please contact the Blue Cross and Blue Shield office for assistance.

HOW TO APPEAL DENIED CLAIMS

If you do not agree with the denial or partial denial of a claim, Delta Dental will review the denial provided that you use the following procedure:

1. Within sixty (60) days after you have received written notice of denial or partial denial of a claim, or your claim has not been processed within the time required by law, you or your duly authorized representative have a right to appeal the denial decision.
2. If you wish to designate a representative, your request for review should be made in a separate letter and indicate the following information:

1. **How Procedures are Selected for Benefit Review**

   There are two criteria which must be met before Benefit Review can be considered an investment in cost containment.

   a. There must be alternate plans of treatment for a given oral condition and each of those plans must produce results within professionally accepted standards.

   b. There must be potential for significant differences in costs between the alternate treatment plans available.

2. **How Benefit Review Occurs**

   When your dentist proposes a course of treatment that includes a procedure which has been designated as requiring Benefit Review, the dentist will:

   a. Complete the Delta Dental Claim Form and indicate that this is a recommendation of services;

   b. Include this claim form and radiographs, other aids to diagnosis and, if necessary, written documentation.

   After it is determined that the patient is eligible for the services recommended and that the recommended services require Benefit Review, the claim, and supporting radiographs and documentation, will be referred to a Treatment Plan Analyst. The Treatment Plan Analyst will always be a dental professional.

   The Treatment Plan Analyst will review claims history within our system, as well as the documentation submitted by the dental office. If the proposed plan of treatment is acceptable, the Treatment Plan Analyst may approve it.

   If there is any question about the treatment plan, the history and documentation will be referred to a dentist consultant currently licensed in Iowa. The dentist may either override or confirm the recommendation made by the Treatment Plan Analyst. Either way, the consultant dentist will contact the practicing dentist to either inform him or her of our decision or to gather additional information which could result in re-evaluation.

   The treatment plan and the radiographs will be returned to your dentist.

   After services are performed by the dentist, the treatment form will be returned to Delta with the actual dates of service. Any services approved but not performed would be crossed-off the treatment form. Any services performed, but not included on the treatment form, would be added.

3. **Responsibility for Submission of Benefit Review Material**

   Eighty-five percent of the dentists in Iowa are **MEMBERS** of Delta Dental. Those dentists will assume the responsibility for submitting benefit review materials on behalf of the subscriber or member.

   However, if a subscriber or member chooses to visit a non-member dentist, the subscriber or member must assume the total responsibility for insisting that the non-member dentist submit benefit review materials to Delta.

There are numerous advantages of utilizing member dentists, since a member dentist assures an employee of the maximum value from the Delta Dental Contract. Member dentists assume responsibility for submitting Benefit Review materials and the subscriber or member will not receive a benefit payment penalty should the dentist fail to follow the proper procedure.

In the case of a non-member dentist, for the subscriber or member to be assured of receiving the full allowable payment, the subscriber or member must assume responsibility of insisting that the dentist submit the required documentation, and the dentist may insist on patient payment for services whether Delta has approved the treatment plan or not.

4. **What Happens if Benefit Review Materials Are Not Submitted?**
   a. First Occurrence

      Benefit Review is designed as a cost containment mechanism. It is not meant to be punitive. The first time a dentist, or a subscriber, fails to submit adequate benefit review documentation prior to performing the service, the service will be accepted, provided it was dentally necessary, and letters will be sent to both the dentist and the subscriber. The letters will inform them that since this is the first occurrence an exception will be made.

   b. Subsequent Occurrences

      If there are further occurrences where adequate documentation is not submitted in advance, claims will not be paid. If there is consistent refusal by a dentist to submit benefit review information necessary to adequately process claims, subsequent claims will be rejected for patients. The same sanctions will be administered against member and non-member dentists. Patients of record will be notified that this dentist is not meeting Delta Dental standards and that claims will not be paid for services performed by that dentist.

      When the dentist agrees to meet Delta's standards, we will begin paying claims again.

5. **Notification of Benefit Review Results**

   Review of treatment plan can result in three findings. Those findings are:

   a. Rejection for eligibility or dental necessity reasons.
   b. Acceptance of the treatment plan as submitted.
   c. Recommendation of an alternate benefit.

   The subscriber and dentist will be notified of Delta's determination.

EXCLUSIONS (NON-PAYABLE SERVICES)

There are some procedures, that most dentists can perform, that are not paid by Delta Dental. Generally these procedures are either cosmetic or not documented by research. For example, if an old filling needs replacing because it is broken, Delta Dental Plan of Iowa will pay for it. However, if you wish to have it replaced because you consider it unsightly, then Delta Dental Plan of Iowa will not pay for it. Putting new veneer on teeth merely because they are stained is considered cosmetic and is not a benefit. Remember, benefits are always restricted to those procedures that are necessary for a healthy mouth.

Restricting the benefits to those procedures that are necessary to maintain and restore your dental health makes good sense. It keeps the price of Delta Dental low enough so that we can all afford the premiums. If you and your dentist have any doubt about whether a service is payable, either you or your dentist can contact Delta Dental Plan of Iowa for the answer (telephone numbers are on the back cover of this booklet.)

ANNUAL MAXIMUM PAYABLE

The annual maximum is the total dollars which Delta will pay for each person covered by a contract. If you have a family contract, Delta will pay up to the annual maximum for **each** covered family member.

Annual maximums should cover most of your dental needs. However, if there was a situation which exceeded that amount, you should discuss the plans for treatment with your dentist. It may be possible to spread out the length of time during which the work will be performed so that more of it can be paid by Delta.

HOW WE DETERMINE WHAT TO PAY: UCR

One of the things that makes Delta Dental a valuable benefit is our method of calculating reasonable payment to dentists.

Some insurance companies simply develop a list of fees that they will pay for each procedure. That list may have been developed in another state or it may not have been updated for several years.

Delta develops its payment allowances from charges actually submitted by Iowa dentists and updates those charges annually. Charges on every procedure by every Iowa dentist are analyzed. We look at information in three categories. The categories are usual, customary, and reasonable.

Delta Dental payment is based upon the Dentist's Usual, Customary and Reasonable Fee.

DENTISTS' CUSTOMARY CHARGE means a statistically derived amount based upon the Dentist's Usual Charges billed by most Dentists within the same geographical locale who have similar training and skills.

DENTISTS' PREVAILING CHARGE means an amount which is statistically derived and will be no less than the median of all Dentists' Usual Charges for the same service billed by most Dentists within the same geographical locale who have similar training and skills.