A Guide to PPO Dental Care Benefits for Fremont Area Medical Center

BlueCross BlueShield of Nebraska

An Independent Licensee of the Blue Cross and Blue Shield Association

About Your Benefit Plan Description

This document is your Benefit Plan Description. It has been written to help you understand your group dental care plan administered in accordance with the provisions set forth in the Master Group Contract and Administrative Service Agreement between Fremont Area Medical Center and your Contract Administrator, Blue Cross and Blue Shield of Nebraska,* an independent licensee of the Blue Cross and Blue Shield Association.

This Benefit Plan Description is only a partial description of the benefits, exclusions, limitations, and other terms of the Master Group Contract to which it refers. It describes the more important parts of that document in a general way. It is not, and should not be considered a contract or any part of one. The Master Group Contract controls the coverage for your group.

Please share the information found in this Benefit Plan Description with your eligible dependents. Additional copies of this document or your Schedule of Benefits, are available from Blue Cross and Blue Shield of Nebraska's Customer Service Center. If you have a question about your coverage or claim, please contact Blue Cross and Blue Shield of Nebraska's Customer Service Center.

**Blue Cross and Blue Shield of Nebraska provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. Blue Cross and Blue Shield of Nebraska liability may occur only under a stop loss provision set forth in the Administrative Services Agreement.*

Fremont Area Medical Center (FAMC)

Summary of Dental Benefits

Effective January 1, 2005

Dental Coverage A: Preventive and Diagnostic Dentistry

Dental Coverage B: Maintenance and Simple Restorative, Oral Surgery, Periodontic Services, and Endodontic Services

Dental Coverage C: Complex Restorative Dentistry

Dental Coverage D: Orthodontic Dentistry

	PPO Provider	Non-PPO Provider
Calendar Year Deductible		
Dental Coverage A:	None	None
Dental Coverages B & C, Combined:	None	$50 per person $150 maximum per family
Dental Coverage D:	None	None
Coinsurance* Amounts		
Dental Coverage A:	None	None
Dental Coverage B:	20%	20%
Dental Coverage C:	50%	50%
Dental Coverage D:	50%	50%
Calendar Year Benefit Maximum		
Dental Coverages A, B and C, Combined:	$1,000 per person	
Total (Overall) Benefit Maximum		
Only Applicable to Dental Coverage D:	$1,000 per person	

* Coinsurance is the percentage of each allowable charge which you must pay.

Important Telephone Numbers

Customer Service:

Omaha 402-390-1820
Toll-free 1-800-642-8980
TTY/TTD (for the hearing impaired) 402-390-1888

Coordination of Benefits:

Omaha 402-390-1840
Toll-free 1-800-462-2924

Subrogation:

Omaha 402-390-1847
Toll-free 1-800-662-3554

Workers' Compensation:

Omaha 402-398-3615
Toll-free 1-800-821-4786

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Some Important Facts About Your Dental Coverage

Your I.D. Card — A Passport to Dental Care

Blue Cross and Blue Shield of Nebraska will issue you an identification card. Your I.D. number is a nine-digit number with an alpha prefix and a numeric suffix. If other members of your family are covered by your membership, their names and dates of birth will also appear on your I.D. card. Each family member will be assigned a different numeric suffix. Only five names can appear on one I.D. card; therefore, you will receive more than one card if there are more than five eligible family members.

Always put your I.D. card in your wallet or purse, along with your driver's license, credit cards and other essential items. With your Blue Cross and Blue Shield of Nebraska I.D. card, U.S. hospitals and physicians can identify your coverage and will usually submit their claims for you.

If you want extra cards for covered family members or need to replace a lost card, please contact Blue Cross and Blue Shield of Nebraska's Customer Service Center. Remember, only persons who are eligible for coverage under your membership may use your Blue Cross and Blue Shield of Nebraska I.D. card.

Schedule of Benefits

Your Schedule of Benefits is a personalized document that provides information concerning: Your dental types of coverage, Preferred and non-Preferred Provider deductible and coinsurance amounts, special benefits, and maximums and limitations of your dental coverage. It also identifies the type of membership option you have.

Selecting A Dental Provider

Selection of a dentist or other provider for your dental services always remains your choice under this group dental plan.

Blue Cross and Blue Shield of Nebraska is the contract administrator for the Fremont Area Medical Center's group dental plan. Within Nebraska, Blue Cross and Blue Shield of Nebraska have contracted with a panel of dentists and physicians who have agreed to a contracted or allowable amount for most services. If you reside in Nebraska, the use of these "Preferred Providers" helps control costs.

Eligibility & Enrollment

Eligibility for Coverage

All non-temporary employees who are regularly scheduled a minimum of 40 hours per two-week pay period are eligible to enroll for coverage after the employee has served a probationary period of 90 consecutive days from the date of hire. Subscribers and dependents must enroll within 31 days of their initial eligibility, or late enrollment provisions may apply. If you acquire dependents through marriage, birth or adoption, a 31-day special enrollment period is allowed to request coverage for them under this group health plan.

Please see the sections titled “Special Enrollment” and “Late Enrollment” for additional information. You may also contact Blue Cross and Blue Shield of Nebraska’s Customer Service Center for information.

Types of Membership

There are four types of enrollment options offered by Fremont Area Medical Center (FAMC). Please check your Schedule of Benefits to see which of the available enrollment options you have.

Please Note: Although FAMC refers to both Subscriber-Spouse and Single Parent memberships as “Single Plus One” memberships, these options will be identified in this book and on your Schedule of Benefits as indicated by the following information.

Single Membership: Provides coverage for you only.

Subscriber-Spouse Membership: Provides coverage for you and your spouse. (FAMC’s Single Plus One)

Single Parent Membership: Provides coverage for you and one eligible dependent child, but not for your spouse. (FAMC’s Single Plus One)

Family Membership: Provides coverage for you, your spouse and your eligible, unmarried children 18 years of age or less who are dependent upon you for support and maintenance. The term "children" includes your biological and adopted children, or a child under a legal guardianship (but does not include a foster child).

“Children” includes a grandchild who lives with you in a regular child-parent relationship if you have been appointed by the court as the child’s legal guardian.

“Children” includes a stepchild only if the child both lives with you and is chiefly dependent upon you for support and maintenance. Even if your spouse is court-ordered to provide insurance and/or financial support to his/her child, if the stepchild does not live with you, he/she is not eligible to be covered by your FAMC plan.

A child is dependent so long as he or she lives with you, the child is provided financial support (either voluntarily or by court order), or the child is provided health coverage by order of the court.

Unmarried children through 23 years of age who are full-time students attending an accredited educational institution and are dependent upon you for support and maintenance are also considered eligible dependent children.

Note: *If two eligible persons in the same employer group are married to each other, each person and/or their eligible dependents may not enroll under more than one membership option.*

Special Enrollment

A special enrollment period of 31 days is allowed for:

- enrollment due to marriage, birth or adoption;
- enrollment of eligible persons not previously covered under the plan due to having had other coverage at the time of initial eligibility, and who have lost that coverage due to:

  exhaustion of coverage under a COBRA continuation provision, or

  a loss of eligibility, termination of employment or reduction in hours, or involuntary termination of such coverage, or

  the employer ceased to make contribution for the other coverage.

Late Enrollment

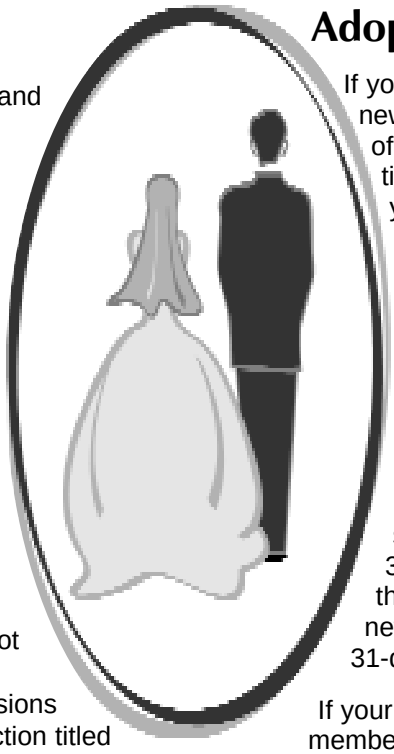
A "late enrollee" is defined as a subscriber or dependent who requests enrollment for coverage more than 31 days after his or her initial eligibility. If you or your eligible dependent(s) do not enroll for dental coverage within 31 days of initial eligibility, enrollment is not allowed until your employer group's next dental annual enrollment month. **In addition, for a "late enrollee," coverage for the first year following the Annual Enrollment month will be limited to Dental Coverage A only.**

Late enrollment for Fremont Area Medical Center is only allowed during the open enrollment month of November of each year. Coverage requested during November will be effective on the first of January of the following year. Please contact the Human Resources Department at Fremont Area Medical Center for information.

Waiting Period for Orthodontic Dentistry

A 12 month waiting period applies to orthodontic dentistry services. This waiting period begins on the effective date of the person's orthodontic dentistry coverage through Fremont Area Medical Center, and ends 12 months after continuous orthodontic dentistry coverage through Fremont Area Medical Center. During the 12 month period, no benefits will be provided for services identified as orthodontic dentistry. This waiting period applies to all enrollees; it is not limited to "late enrollees."

Marriage



When you marry, your spouse and any other new dependents are eligible to enroll for coverage under an appropriate membership unit offered by your group plan. A 31-day period is allowed to make a change to your membership if necessary, and to request coverage for the new dependents. If the request is received within 31 days of the marriage, the effective date of coverage will be no later than the first day of the first month following the receipt of the enrollment form.

If the request for coverage is not made within 31 days of the marriage, late enrollment provisions may apply. Please see the section titled "Late Enrollment" for additional information.

Newborn Children

If you have a Family Membership in effect on the date of birth, coverage shall begin at birth for your newborn child. Please notify Blue Cross and Blue Shield of Nebraska of the birth within 31 days, so that they may update your records.

If you have a Single or a Subscriber-Spouse Membership in effect at the time of birth, or if you have a Single Parent Membership in effect that already provides coverage to another eligible dependent child, coverage for your newborn will only be provided if you request a change to a Family Membership (or to a Single Parent Membership, if applicable) within 31-days of the birth, and pay the additional premium.

If your spouse was not enrolled under your membership at the time of the child's birth, he or she may also enroll for coverage during this 31-day period, and the effective date of coverage for your spouse will be the date of the child's birth. The applicable premium for Family Membership must be paid for the entire month. Please contact FAMC for premium information.

If you request enrollment of the child (and spouse, if applicable) after the 31-day period, late enrollment provisions may apply.

Adopted Children

If you are adopting a child, the effective date of the newly adopted child's coverage will be the earlier of the date the child is placed with you for adoption, or the date a court order grants custody to you. Please notify Blue Cross and Blue Shield of Nebraska within 31 days of the placement, so that they may update your records.

If you have a Single or a Subscriber-Spouse Membership in effect at the time of the adoption, or if you have a Single Parent Membership in effect that already provides coverage to another eligible dependent child, you must request a change to a Family Membership (or to a Single Parent Membership, if applicable) and enroll the child within 31 days of the placement for adoption and pay the additional premium in order to continue the newly adopted child's coverage beyond the initial 31-day period.

If your spouse was not enrolled under your membership at the time of the adoption, he or she may enroll for coverage during this 31-day period, and the effective date of coverage for your spouse will be the date the child is placed with you for adoption. The applicable premium must be paid. Please contact FAMC for premium information.

If you request enrollment of the child (and spouse, if applicable) after the 31-day period, late enrollment provisions may apply.

Disabled Dependent Children

A physically or mentally disabled child may remain an eligible dependent child upon reaching age 19 if incapable of self-sustaining employment, or of returning to school as a full-time student, by reason of mental or physical handicap, and dependent upon you for support and maintenance. The application for such coverage must be received within 31 days of the dependent's 19th birthday and the dependent must meet all other group coverage eligibility requirements.

A child who becomes physically or mentally disabled while a covered student over 18 years of age may continue under your dental care coverage while remaining incapable of returning to school as a full-time student, unmarried and dependent upon you for support and maintenance. You must furnish proof of disability within 31 days of its onset. (This extended coverage is subject to all other group coverage requirements.)

An application for extension of dependent coverage is available through Blue Cross and Blue Shield of Nebraska's Customer Service Center.

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order (QMCSO) is a court order that requires an employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or paternity disputes. The order may direct the group health plan to enroll the child(ren), and also creates a right for the alternate recipient to submit claims and receive benefits for services.

QMCSO are specifically defined under the law, and are required to include certain information in order to be considered "qualified." A National Medical Support Notice received by the employer or plan from a state agency, regarding coverage for a child, will also be treated as a QMCSO. The Plan Administrator or its designee, will review the Order or Notice to determine whether it is qualified, and make a coverage determination. The Plan Administrator or its designee will notify affected employees and the alternate recipient(s) if a QMCSO is received.

You have the right to request a copy of the Plan's procedures governing QMCSO determinations from the Plan Administrator, at no charge.

Active Employees Ages 65 and Over

Federal law affects the way employers provide coverage to eligible active employees and their spouses who are 65 and over. These active employees and their spouses ages 65 and over may elect to continue full benefits under the employer group benefit plan or choose Medicare as their primary coverage. If Medicare is elected as the primary carrier (the plan that pays first), coverage under the group plan is terminated. If the group plan is elected as the primary carrier (the plan which pays first), Medicare becomes the secondary coverage.

Family Medical Leave Act (FMLA)

Public Law 103-3 (FMLA) requires that, subject to certain limitations, an employer of 50 or more persons offer continued coverage to employees and their eligible dependents, while the employee is on FMLA leave for birth, adoption or foster care placement of a child, or due to a serious health condition of the employee or his/her son, daughter, spouse or parent. In addition, an employee who has terminated his/her group health plan coverage while on approved FMLA leave may reenroll for group health plan coverage upon return to employment. **Please check with your employer for details regarding your eligibility under FMLA.**

Termination Of Coverage

Coverage under your dental plan will terminate on the earliest of the following dates:

- The date the entire Contract is terminated.
- The last day of the month in which you terminate employment.
- The last day of the month in which you cease to be eligible under the dental plan, or a dependent ceases to be an eligible dependent.
- The last day of the month in which Blue Cross and Blue Shield of Nebraska receives a request from you or the employer to terminate coverage for you or a dependent, or the date requested in the notice, if later.
- The last date for which premium was paid.

You and/or your eligible dependents may be eligible to continue coverage under the dental plan, as detailed in the following sections.

Special Note: If you choose to cancel your dental coverage, you may not re-enroll for dental coverage for two years from the first of the month following the date of your cancellation. If you should end your employment, your dental coverage will also end and no conversion rights are available.

Continuation Of Coverage

Under **federal Public Law 99-272**, known as COBRA, covered employees and their dependents may elect to continue coverage under the group plan upon the occurrence of certain "qualifying events." These events are described on the following pages, as well as the procedures for electing COBRA continuation coverage. **Payment for continuation coverage is at the employee's or dependent's own expense.**

Please share the COBRA information found in this section with your eligible dependents.

Termination of Employment or Reduction in Hours

When leaving your job, you may be eligible for continued coverage under your group plan. Public Law 99-272, (COBRA), and its subsequent amendments provides that if you should lose eligibility for coverage due to:

- a reduction in work hours
- termination of employment
- a layoff, or
- discharge for misconduct (other than gross misconduct),

you and your covered dependents may be able to continue the group coverage at your own expense for **up to 18 months.** Your employer is required to notify the plan administrator within 30 days. The plan administrator will send you a COBRA notification within 14 days after receiving notice from the employer.

Disability--If the Social Security Administration determines that you or a covered dependent are disabled any time during the first 60 days of COBRA coverage, you may be entitled to extend the COBRA coverage from **18 to 29 months.** You must provide notice of the disability determination to the plan within 18 months of your COBRA eligibility date, and no later than 60 days after the date of the Social Security Administration's determination.

If the Social Security Administration determines that you or the dependent are no longer disabled, the extended continuation of coverage (19th through 29th month) will be terminated the month that begins more than 30 days after the final determination. You must notify the plan within 30 days of a final determination that the individual is no longer disabled.

Special provisions regarding COBRA eligibility for certain retirees may apply if an employer files a Chapter 11 bankruptcy. Please check with your employer for details.

Change in Dependent Status, Divorce or Separation or Medicare Entitlement

Public Law 99-272 (COBRA), and its subsequent amendments, requires that continued coverage under your group plan be offered to your covered spouse and eligible dependent children if they would otherwise lose coverage as the result of:

- a child losing dependent status
- divorce or legal separation, or
- you becoming entitled to Medicare.

When one of these circumstances occurs, you are obligated to notify your employer or plan administrator within 60 days.

After receiving a timely notice of such an event, your employer or plan administrator will send your spouse or dependents an election form and information needed to apply for coverage, if eligible. The coverage may be continued at his/her expense **for up to 36 months.**

Your Death

If you should die while you are covered under this group plan, continued coverage under this group plan is available to your spouse and eligible dependents.

Public Law 99-272 (COBRA), and its subsequent amendments, provides that subject to certain limitations, your surviving spouse and children may continue the group coverage at their own expense for up to 36 months. **Federal law requires your employer to send the surviving family members instructions as to how to apply for continued coverage, if they are eligible.**

Electing COBRA Coverage

Please share the COBRA information found in this section with your eligible dependents, in the event that a qualifying event occurs.

Within 14 days after notice of a qualifying event is received by the plan administrator, you and/or your dependents will be sent a written notice of the right to continue health coverage and an election form(s).

Reminder: *In the case of a divorce or legal separation, or if a child loses dependent status, you must notify your employer or plan administrator of this qualifying event within 60 days after the later of the event or the date the coverage would be lost.*

You and/or your dependents must complete and return the COBRA election form in order to continue coverage. The notice will include instructions to help you complete the form, and to whom it should be sent.

The election form must be received by the later of:

- 60 days after the day health coverage would otherwise end, or
- 60 days after the notice is sent to you by the employer or plan administrator.

COBRA continuation coverage may only begin on the day after coverage under the plan would otherwise end. You or your dependents must pay the required premium, including any retroactive premium, from the day coverage would have otherwise ended. The premium must be paid within 45 days after the day continued coverage is elected. Succeeding premiums must be paid monthly within 30 days of the premium due date. The COBRA notice and election form will inform you or your dependents of the monthly premium amount, and to who such premium should be paid.

Termination of COBRA Coverage

An insured person's COBRA continuation coverage will end at midnight on the earliest of:

- the day your employer ceases to provide any group health plan to any employee,
- the day the premium is due and unpaid,
- the day an insured person first becomes covered under any other group health plan (after the COBRA election), which does not exclude or limit any pre-existing conditions or to whom such an exclusion is not applicable due to creditable coverage,
- the day an insured person again becomes covered as an employee or dependent under the policy,
- the day an insured person becomes entitled to benefits under Medicare (after the COBRA election), or
- the day health insurance has been continued for the maximum period of time allowed (18, 29 or 36 months).

Note: *In the event more than one continuation provision applies, the periods of continued coverage may run concurrently, but never for more than 36 months.*

Understanding Your Dental Coverage

Your group dental plan is designed around four categories of dental coverage. The four types of dental coverage included in your group dental plan are identified below, and are described in detail in the next section of this book.

Dental Coverage Type A:
Preventive and Diagnostic Dentistry

Dental Coverage Type B:
Maintenance and Simple Restorative Dentistry, Oral Sugery, Periodontic and Endodontic Dentistry

Dental Coverage Type C:
Complex Restorative Dentistry

Dental Coverage Type D:
Orthodontic Dentistry

The dental benefits available to you under these four categories work together to provide you with a dental care program. The way benefits are determined on this dental plan depends on whether the dental service or treatment falls under Dental Coverage Type A, B, C or D.

Important Dental Coverage Terms

Allowable Charge — Payment is based on the allowable charge for a covered service. Generally, the allowable charge for services by Preferred or Contracting Providers will be a contracted amount for the service. The allowable charge for services by non-Contracting Providers will generally be the lesser of the billed charge or Maximum Benefit Amount for the service. Refer to the Definitions section in the back of this document for details.

Coinsurance — The percentage of the allowable charge which you must pay, after any applicable deductible is applied. Your Schedule of Benefits and the chart in the front of this book identifies what coinsurance amount is applicable to what dental care services. The coinsurance percentage is determined based on whether the dental service falls under Dental Coverage Type A, B, C or D.

Deductible — A deductible is applicable to Dental Coverage Types B and C (combined) as shown on your Schedule of Benefit and on the chart in the front of this book. A deductible is the amount you must pay for Dental Coverage Types B and C, combined before dental benefits begin. The deductible applies each calendar year to each covered person; however, for a family, the maximum deductible amount is limited to three times the individual deductible amount per calendar year. After the deductible is met, benefits for the rest of that calendar year will not be subject to any further deductible.

Note: Charges for noncovered services or amounts in excess of the allowable charge do not count toward your deductible.)

Maximum Benefits — Your Schedule of Benefits and the chart in the front of this book identifies a maximum dollar amount available per covered person per calendar year. After that maximum benefit amount has been provided toward the specific Dental Coverage Type(s) for a covered person in one calendar year, additional benefits are not available for the rest of that calendar year.

Total (Overall) Benefits — Your Schedule of Benefits and the chart in the front of this book identifies a total, overall maximum dollar amount available per covered person. After the total (overall) benefit amount has been provided toward that specific Dental Coverage Type for a covered person, additional benefits are not available for any other services that person receives for that specific Dental Coverage Type.

Utilization Review

Benefits are available under the group dental plan for **medically necessary** services. Services provided by all providers are subject to **utilization review** by Blue Cross and Blue Shield of Nebraska. Services will not automatically be considered medically necessary because they have been ordered or provided by a physician or dentist. Blue Cross and Blue Shield of Nebraska will determine whether services provided are medically necessary under the terms of the plan, and benefits available. **The Definition section in the back of this book define medically necessary and utilization review.**

Fraud or Misrepresentation

A covered person's coverage may be canceled or rescinded for fraud or misrepresentation about a claim or eligibility for this coverage. If coverage is rescinded, the amount of premium paid will be reduced by any benefits that were paid, and will be refunded. If benefits paid exceed the premium received, we may recover the difference.

Medical Records

In consideration for the processing of claims, Blue Cross and Blue Shield of Nebraska will be entitled to receive such facts, records, and reports about the examination or treatment of Covered Persons as may be needed to process claims or to determine the appropriateness of benefit payment. The Covered Person agrees that in consideration for benefits available, he or she consents to the release of such information to Blue Cross and Blue Shield of Nebraska.

Covered Dental Services

Covered dental services under the Fremont Area Medical Center group dental plan are split-up between four coverage categories; Dental Coverage Types A, B, C and D.

Coverage A - Preventive and Diagnostic Dentistry

- Two oral examinations each calendar year (other than emergency exams).
- Medically necessary dental consultations.
- Two treatments including cleaning, scaling and polishing teeth each calendar year.
- Two topical fluoride applications each calendar year for covered persons under age 16.
- Dental x-rays (intraoral, bitewing, occlusal periapical, extraoral), but not more than one series of full-mouth or panorex x-rays in any period of three consecutive calendar years, and one set of four supplemental bitewing x-rays in a calendar year.
- Application of sealants to the permanent first and second molar teeth of covered persons under age 16, but not more often than once every four years.
- Space maintainers for prematurely lost primary teeth for covered persons under 16 years of age.
- Pulp vitality tests.

Note: Benefits are limited to one oral exam per day, during one office visit.

Coverage B - Maintenance and Simple Restorative Dentistry, Oral Surgery, Periodontic and Endodontic Dentistry

- Oral surgery consisting of:

  simple and impacted extractions (excluding orthodontic extractions);

  alveoloplasty;

  removal of dental cysts and tumors;

  surgical incision and drainage of dental abscess;

  tooth replantation;

  excision of hyperplastic tissue; and

  the reduction of a complete dislocation or fracture of the temporomandibular joint of the jaw required as a direct result of an accidental injury occurring while the patient is covered under this group plan. Benefits are limited to treatment provided within 12 months of the date of injury. Injuries resulting from eating, chewing or biting are not covered.

- Periodontic services (treatment of diseases of gums and supporting tooth structure) consisting of:

  up to four periodontic cleanings per calendar year;

  gingivectomy;

  gingival curettage;

  osseous (bone) surgery, including flap entry and closure;

  osseous (bone) graft;

  scaling and root planing;

provisional or permanent periodontal splinting;

mucogingivoplastic surgery; and

treatment of acute infection and oral lesions.

- Endodontic services (treatment of diseases and injuries of the tooth pulp chambers, root canals and periapical tissue) consisting of:

  pulp capping;

  vital pulpotomy;

  root canal therapy including treatment plan, diagnostic x-rays, clinical procedures and follow-up care;

  apical curettage;

  root resection; and

  hemisection.

- Medically necessary general anesthesia when administered in conjunction with covered oral or dental surgery, provided the anesthetic agent produces a state of unconsciousness in the patient.

- Restorations consisting of silver amalgam and/or composite materials. (If gold is used as a filling material, benefit payment will be made as for amalgam.)

- Temporary crowning of teeth as a result of an accident, if provided within 72 hours of the accident.

- Pre-formed stainless steel or acrylic crowns on diseased or damaged teeth.

- Recementing inlays and crowns on diseased or damaged teeth.

- Pain relieving treatment limited to opening and draining of a tooth when no endodontic treatment follows; smoothing down chipped teeth; dry socket treatment; pericoronitis treatment or treatment for apthous ulcers (canker sores).

- Repair of dentures, bridges, crowns and cast restorations.

Coverage C - Complex Restorative Dentistry

- Crowns.

- Inlays when used as abutments for fixed bridgework.

- Installation of permanent bridges.

- Full and partial dentures.

- One denture relining each 36 consecutive month period.

- Adjustments of dentures after six months from the date of installation.

Coverage D - Orthodontic Dentistry

(Note: Remember, there is a 12 month waiting period before benefits for this coverage are available.)

- Orthodontic x-rays.

- Surgical exposure to aid eruption.

- Orthodontic extractions.

- Orthodontic casts and models.

- The initial and subsequent installations of orthodontic appliances, and orthodontic treatments.

Note: Blue Cross and Blue Shield of Nebraska may request all x-rays records and information concerning proposed or provided dental services.

Other Important Dental Information

IF YOU'RE TREATED BY MORE THAN ONE DENTIST OR PHYSICIAN

If you transfer from the care of one dentist (or physician) to another during the course of treatment, or if more than one dentist (or physician) provides services, this plan will provide benefits as if only one dentist (or physician) provided the service.

USE OF THE LESSER CHARGE

Where there are optional techniques of dental treatment with different charges, this group dental plan will provide benefits for the lesser charge.

PERSONALIZED AND SPECIAL TECHNIQUES

If, in the construction of a denture, you and your dentist decide on personalized restoration or to employ special techniques as opposed to standard procedures, the dental benefits provided under this group plan shall be limited to the standard procedures for such services.

SPECIAL PROVISIONS FOR LIMITED EXTENSION OF DENTAL BENEFITS

A covered person is entitled to a limited extension of benefits for covered dental services, for up to 30 days after termination of coverage under this group dental plan for the following services:

- root canal therapy, but only if the pulp chamber was opened and the pulp canal explored to the apex while the patient was covered under this group dental plan,
- crowns, bridges, inlays or onlay restorations, but only if the tooth or teeth were fully prepared while the patient was covered under this group dental plan, and
- full or partial dentures, but only if the master impression was made while the patient was covered under this group dental plan.

This limited extended dental coverage ceases the earliest of:

- the end of the 30-day extension period; or
- the date the patient becomes eligible for such dental services under another group plan.

This limited extension of dental benefits is applicable only for the Dental Coverage Type B and C services.

PREAUTHORIZATION OF DENTAL TREATMENT

A dental treatment plan is a written report showing a recommended dental treatment program prepared by a dentist (or physician) as a result of an examination made by the dentist (or physician).

A dental treatment plan must be submitted by your dentist (or physician) for Dental Coverage Type B and C services that are estimated to exceed $500 in expense.

This written preauthorization of benefits for a dental treatment plan should be addressed to:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-0001

Blue Cross and Blue Shield of Nebraska will advise you and your dentist (or physician) whether or not benefits are available. If your provider does not agree with their decision, he/she may appeal by submitting additional information to them for review. Blue Cross and Blue Shield of Nebraska will then notify both you and your dentist (or physician) of the decision.

If the dentist (or physician) bills a single charge for the entire dental treatment, benefit payment for covered dental services will be provided as follows:

- If the expected period of dental treatment is 2 years or more, Blue Cross and Blue Shield of Nebraska will divide the charge by eight and pay the quarterly dental benefit amounts accordingly.
- If the expected period of dental treatment is less than 2 years, Blue Cross and Blue Shield of Nebraska will divide the charge by the number of full 3 month periods in the period of treatment, and pay the appropriate dental benefit amount at the end of each 3 month period.

Adjustment will be made, if necessary, by reason of change in the estimated single charge, change in the estimated period of dental treatment, or termination of the covered person's dental coverage.

Please remember that preauthorization of dental benefits for a dental treatment plan does not guarantee benefit payment. All other provisions of your dental plan's Master Group Contract apply. For example: deductibles, coinsurance, exclusions or any other limitations of your group dental coverage.

Noncovered Services And Supplies

This group dental plan provides benefits for a wide variety of dental care expenses. However, there are some services and supplies that are not covered.

Noncovered services include:

- Services that are not described as covered dental services in this plan's Master Group Dental Contract; or dental services to the extent that they exceed the limitations stated in your plan's Master Group Dental Contract.
- Services not considered by Blue Cross and Blue Shield of Nebraska to be payable after consideration by their Utilization Review Program. The Utilization Review Program consists of evaluating the use of a dental, medical or surgical procedure or service or the utilization of dental or medical supplies compared to established criteria, to determine whether benefits are payable. Benefits will not be provided for services, procedures or supplies which are determined by the Utilization Review Program to be not medically necessary.
- Services, procedures and supplies which are considered by Blue Cross and Blue Shield of Nebraska to be investigative, or for any related services or complications.
- Any amount over the actual charge for a covered dental service, or in excess or the allowable charge.
- Dental services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group.
- Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes.
- Charges for gnathologic tests, orthognathic surgery, osteoplasties, osteotomies, Le Fort procedures, vestibuloplasties and stomatoplasties.
- Appliances, devices, procedures, dentures or restorations necessary to modify vertical dimensions of, or restore, the occlusion, or to replace tooth structure lost through attrition, erosion abrasion or any expense for occlusal adjustment or equilibration.
- Gold restorations (except as specified in the section of this book titled "Covered Dental Services).
- Retreatment or adjustment, recementation, reline, rebase, replacement or repair of cast restorations, crowns, and prostheses when made by the same dentist or dental office which provided the initial service, either within six months of the completion of the service or within any time frame, if the initial service is not adequate to meet nationally accepted dental standards.
- Charges made for missed appointments, filling out claims forms or furnishing any other records or information or special charges such as dispensing fees, administrative fees, technical support or utilization review charges which are normally considered to be within the charge for a service.
- Replacement of third molars with prostheses.
- Any dental appliances or prosthesis replacement made necessary by reason of loss or theft of the dental appliance or prosthesis.
- Full or partial denture replacement for any denture replacement made necessary by reason of the loss or theft of a denture.
- Full or partial replacement for crown, bridge, inlay and denture replacement made less than 5 years after placement or replacement which was covered under this plan's Master Group Contract.
- Caries susceptibility tests, bacteriologic studies or histopathologic exams.
- Magnetic resonance imaging.
- Education or training in, and supplies used for dietary or nutritional counseling, personal oral hygiene or dental plaque control.
- Services for the correction of the temporomandibular (jaw) joint.
- For implants or any procedure associated with the preparation for, maintenance of or placement or removal of implants. (Implants are defined as artificial material grafted or implanted into or onto bone.)

- For any procedure begun after you or your dependent's coverage terminates or for any prosthetic dental appliance installed or delivered more than 30 days after such coverage terminates.
- Services, procedures and supplies which are considered by Blue Cross and Blue Shield of Nebraska to be for cosmetic purposes, or for any related services or complications.
- Services, procedures and supplies which are considered by Blue Cross and Blue Shield of Nebraska to be obsolete, or for any related services. Procedures will be considered to be obsolete when such procedures have been superseded by more efficacious treatment procedures and are generally no longer considered effective in clinical medicine.
- Services provided to or for:

  any dependent of a covered person who has a Single Membership;

  any person who does not qualify as an eligible dependent;

  any covered person before his or her effective date of coverage, or after the effective date of cancellation or termination of this coverage.

  any conditions for which coverage has not yet become effective because of waiting periods.
- Interest, sales or other taxes or surcharges on covered services or supplies. (This includes taxes or surcharges levied by governmental bodies or subdivisions who do not have jurisdiction over this plans' Master Group Contract.)
- Dental services for illness or injury caused directly or indirectly by war or any act of war, declared or undeclared, or sustained while performing military service.
- Services provided in or by a Veterans Administration Hospital where the care is for a condition related to military service, or any non-participating hospital or other institution or facility which is owned, operated or controlled by any government agency (except where care is provided to a nonactive duty covered persons in medical facilities).
- The portion of benefits provided at government expense, (except:Medicaid) whether or not you elect to receive such benefits. This will not apply to Medicare-eligible employees or spouses of employees ages 65 or over who have elected this group dental plan as their primary carrier.
- Services for which the covered person is not legally obligated to pay, or for which no charge would be made if this coverage did not exist, including any charge above the charge that would have been made if this coverage did not exist or for any service which is normally furnished without charge.
- Services covered under any Workers Compensation or Employers Liability Law, whether or not the covered person asserts rights to such coverage.
- Charges for services provided by a person who is a member of the covered person's immediate family by blood, marriage or adoption.
- Charges for services by a health care provider which are not within his or her scope of practice or charges by a person who is not an approved provider.
- Services to the extent they are not payable due to Coordination of Benefits.
- Charges made separately for services, supplies and materials when such services, supplies and materials are considered by Blue Cross and Blue Shield of Nebraska to be included within the charge for a total service payable under this plan's Master Group Contract, or if the charge is payable to another provider.
- Charges for services resulting from an intentionally inflicted injury, engaging in an illegal occupation or resulting from commission of or attempting to commit a felony.
- Services for dental treatment whether compensated or not which are directly related to or resulting from the covered person's participation in a voluntary, investigative test or research program or study which is not conducted in a dental-office setting.
- Expense for any procedure provided by a person who is not a dentist or dental hygienist or who is not under the direct supervision of a dentist.
- Charges for services provided by a hospital, ambulatory surgical facility, or any other facility charge.

Coordination Of Benefits

Employers and insurance companies that provide dental care coverage cooperate with one another to avoid duplication of payments and generate savings. These practices, called “coordination of benefits” dictate which company is primary, that is, which company pays first.

Definitions for Coordination of Benefits

Allowable Expense: Any necessary, reasonable and customary item of expense covered in whole or in part by this plan or another plan during a claim determination period. When benefits are in the form of services rather than cash payments, the reasonable cash value of each service shall be both an allowable expense and a benefit paid. Benefits payable under a plan include the benefits that would have been payable had a claim been made.

Automobile No-fault Contracts: Insurance under which benefits are payable by the insurer for expenses of hospital and medical care of injuries resulting from an automobile accident regardless of negligence.

Claim Determination Period: The period of a calendar year over which allowable expenses are compared with total benefits in the absence of this provision. However, it does not include any part of a year during which a person does not have coverage under this plan, or any part of a year before the date this coordination of benefits provision or a similar provision took effect.

Insurer: An insurance company, a health maintenance organization, a preferred provider organization, a dental service corporation or a nonprofit hospital service corporation.

Plan: Any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits are provided by:

- group, blanket or franchise insurance coverage;
- uninsured arrangements of group or group-type coverage;
- any coverage under labor management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans;
- hospital indemnity type coverages written on a non-expense incurred basis to the extent the benefits available are more than $200 per day;
- both group and individual automobile no-fault contracts;
- group or group-type automobile fault contracts; and
- group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans.

The term "plan" as defined for the purpose of coordination of benefits does not mean:

- grammar school, high school, or college accident-type coverages, written on either an individual, group, blanket or franchise basis;
- individually underwritten and issued hospital, expense or dread disease policies;
- hospital indemnity type coverages written on a non-expense basis to the extent the benefits available are equal to, or less than, $200 per day;
- non-group individual or family insurance or subscriber contracts;
- non-group individual or family coverage through health maintenance organizations (HMOs);
- non-group individual or family coverage under other prepayment, group practice or individual practice plans;
- plans whose benefits, by law, are in excess to those of any private insurance program or other nongovernmental program.

Primary Plan: The plan which will determine allowable benefits without regard to other covered allowable expenses.

Secondary Plan: The plan which will determine allowable benefits for the balance of the remaining charges in the claim determination period.

Primary Plan/Secondary Plan: The order of benefit determination rules state whether this plan is a primary plan or secondary plan as to another plan covering the person. When this plan is a primary

plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, this plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.

Order of Benefits

If benefits are payable under any other plan or no-fault automobile insurance coverage which does not provide for coordination of benefits, the insurer or plan providing that coverage shall be the primary carrier.

Whenever the benefits payable under any other plan are determined with regard to the benefits payable under this contract, then the primary carrier will be the organization which is the one which satisfied the first one of the following tests by providing a plan to the covered person:

- The plan which covers the person as an employee/subscriber is primary to the plan covering the person as a dependent.
- For a child of parents not separated or divorced, the primary plan is the plan of the parent whose birthday falls earlier in the year. Where both parents have the same birthday, the primary carrier shall be the one which has covered the parent for the longer period of time.
- For a child of parents who are divorced or separated, first shall be the plan of the custodial parent, then the plan of the spouse of the custodial parent, and then the plan of the non-custodial parent. However, if there is actual knowledge that the divorce decree or qualified court order requires one parent to be responsible for health care expenses, the primary carrier shall be the plan provided by that parent.
- The plan of an employee who is neither laid off nor retired (or as that employee's dependent) is primary to the plan which covers that person as a laid off or retired employee (or that employee's dependent). If the other health benefit plan coverage does not have this provision and, if as a result, the carriers do not agree on the order of benefits, this section is ignored.
- A plan providing coverage to a person under federal (COBRA) or state continuation law is secondary to a plan providing coverage to that person as an employee, subscriber, retiree (or that person's dependent).
- If none of the prior rules determines the order of benefits, the benefits of the plan which covered a subscriber longer are determined before those of the plan which covered that person for the shorter time.

Administration of Coordination of Benefits

If this plan is the primary plan, there shall be no reduction of benefits paid under this plan--benefits will be paid as if the other plan did not provide benefits.

If this plan is the secondary plan, its benefits will be determined after those of the other plan, and may be reduced because of the other plan's benefits.

Payment will not be made for any amount for which the covered person is contractually held harmless by either plan. Payment between the plans shall not exceed the amount paid under this contract, had it been primary.

To properly administer coordination of benefits, this plan may obtain from or release to any insurance company or other organization or person, any information necessary to determine whether coordination of benefits applies. Any person who claims benefits under this plan agrees to furnish this plan information that may be necessary to effect coordination of benefits.

If another plan pays benefits which should have been paid under this contract, then this plan will reimburse such other plan any amounts determined to be necessary. Amounts paid to other plans in this manner will be considered benefits paid under this plan. This plan is also released from liability of any such amount paid in this manner.

If the benefits paid by this plan exceed what should have been paid, this plan has the right to recover any excess from any insurer, any other organization, or any person to or for whom such payments are made, including covered persons under this plan.

This plan's duty regarding coordination of benefits, is limited to making a reasonable effort to avoid liability as the primary plan in appropriate cases brought to its attention; to making reasonable efforts to compute the amount payable under any other plan; and to making reasonable efforts to recover any excess payments made by it.

Subrogation (Third Party Liability)

Subrogation is the right to recover benefits paid for covered services provided as the result of an injury or illness which was caused by another person or organization. If this group dental plan pays benefits for covered services provided to a covered person as the result of an injury or illness, this group dental plan is allowed to be reimbursed the amount paid for such services by the covered person if the covered person or the person who has the right of recovery for a covered person (usually a parent or spouse), recovers the cost of such services from the person who caused the injury or illness, or from that person's liability insurance carrier.

The covered person agrees to assist the group dental plan in any way necessary to recover such payments. The covered person agrees not to prejudice this group dental plan's right to recovery. If a covered person refuses or fails to comply with this subrogation, this group dental plan may cancel such covered person's dental coverage, including that of any covered dependents.

By accepting coverage under this group dental plan, the covered person agrees that this group dental plan may collect from the proceeds of any settlement, judgement or otherwise, recovered on his or her behalf regardless of whether or not there has been full compensation. He or she further agrees that this group dental plan is granted a contractual right to collect reimbursement from the proceeds of any such recovery regardless of whether or not there has been full compensation. This right of recovery is cumulative with and not exclusive of this group dental plan's subrogation right. This right of recovery shall be a prior lien against any proceeds recovered, and it shall not be defeated by allocating the proceeds exclusively to non-medical damages.

No adult covered person may assign any rights to recover dental expenses from any third party to any minor or other dependent of the adult covered person or to any other person, without the express written consent of Blue Cross and Blue Shield of Nebraska. This right to recover, whether by subrogation or other reimbursement, shall apply to settlements or recoveries of deceased persons, minor dependents of a covered person, incompetent or disabled covered persons or their incompetent or disabled dependents.

The covered person agrees to assist Blue Cross and Blue Shield of Nebraska in any way necessary to recover such payments, including, but not limited to notifying Blue Cross and Blue Shield of Nebraska of a subrogation claim or lawsuit. The covered person agrees not to interrupt or prejudice this group dental plan's right to recover.

If the covered person refuses or fails to comply, Blue Cross and Blue Shield of Nebraska may cancel such covered person's dental coverage, including that of any covered dependents. Blue Cross and Blue Shield of Nebraska shall also be entitled to recover any costs incurred in enforcing these provisions, including, but not limited to, attorneys' fees, litigation and court costs and other expenses.

Subrogation does not apply to recoveries made by covered persons from no-fault insurance. Recoveries made by the covered person from no-fault insurance are subject to Coordination of Benefits, unless otherwise provided by applicable state law.

Workers' Compensation

Benefits are not available for services provided as the result of illness or injury arising out and in the course of employment for which an employer is required to furnish or pay, or for which settlement is made, according to Workers Compensation laws. In certain instances, benefits for such services are paid in error under this dental care plan. If this happens, Blue Cross and Blue Shield of Nebraska will request reimbursement for these payments from the covered person. This reimbursement may be funded from any recovery made from such employer, or the employer's Workers' Compensation carrier.

Claim Procedures

Filing a Claim

Contracting Providers and many other hospitals, dentists and physicians will file a claim form to Blue Cross and Blue Shield of Nebraska on your behalf.

You must file your own claim form if your health care provider does not file for you. Claim forms are available at Blue Cross and Blue Shield of Nebraska's Customer Service Center.

All submitted claims must include:

- Correct Blue Cross and Blue Shield of Nebraska ID number, including the alpha prefix.
- Name of patient.
- The date and time of an accident or onset of an illness, and whether or not it occurred at work.
- The name and identification number of other insurance, including Medicare.
- Diagnosis.
- An itemized statement of services, including the date of service, description and charge for the service.
- Prescription number, if applicable.
- Complete name, address and professional status (D.D.S., M.D., etc.) of the dental care provider.

Claims cannot be processed if they are incomplete, and may be denied for "lack of information" if required information is not received.

Claims should be filed as soon as possible. If a claim is not filed, or any revisions or adjustments to a claim are not filed within 18 months of the date of service, benefits will not be allowed. Claims, including revisions or adjustments, that are not filed by a Nebraska contracting provider prior to the claim filing limit, will become the Nebraska Contracting Provider's liability.

In Nebraska, claim forms should be mailed to:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, Nebraska 68180-0001

Claim Determinations

A "claim" may be classified as "pre-service" or "post-service."

Pre-Service Claims — In some cases, under the terms of the dental plan, the covered person is required to preauthorize benefits in advance of a service being provided, or benefits will be reduced or denied for the service. This required request for a benefit is a "pre-service claim." Pre-service claim determinations will be made within 15 days, unless an extension is necessary to obtain needed information. If additional information is requested, the covered person or his or her provider may be given up to 45 days from receipt of the notification to submit the requested information. A claim determination will be made within 15 days of receipt of the information, or the expiration of the 45-day period. You, and/or your provider will be advised of the determination, in writing.

Post-Service Claims — A post-service claim is any claim that is not a pre-service claim. In most cases, a post-service claim is a request for benefits or reimbursement of expenses for medical care that has been provided to a covered person. The procedure for filing a post-service claim is outlined previously under "Filing a Claim." Upon receipt of a completed claim form, a post-service claim will be processed within 30 days, unless additional information is needed. If additional information is requested, the covered person or his or her provider may be given up to 45 days to submit the necessary information. A claim determination will be made within 15 days of receipt of the information, or the expiration of the 45-day period. You will receive an Explanation of Benefits when a claim is processed, which explains the manner in which your claim was handled.

Who Receives The Benefit Payment

Benefit payments for covered services provided by Preferred Providers or any providers who are participating with Blue Cross and Blue Shield of Nebraska, will be made directly to the providers unless otherwise provided under state or federal law. Benefits may also be paid to an alternate recipient or custodial parent, pursuant to a qualified medical child support order. In all other cases, payments will be made, at Blue Cross and Blue Shield of Nebraska's option, to the covered person, to his or her estate, or to the provider. No assignment for services, whether made before or after services are provided, of any amount payable according to this group benefit plan shall be recognized or accepted as binding upon Blue Cross and Blue Shield of Nebraska, unless otherwise provided by state or federal law.

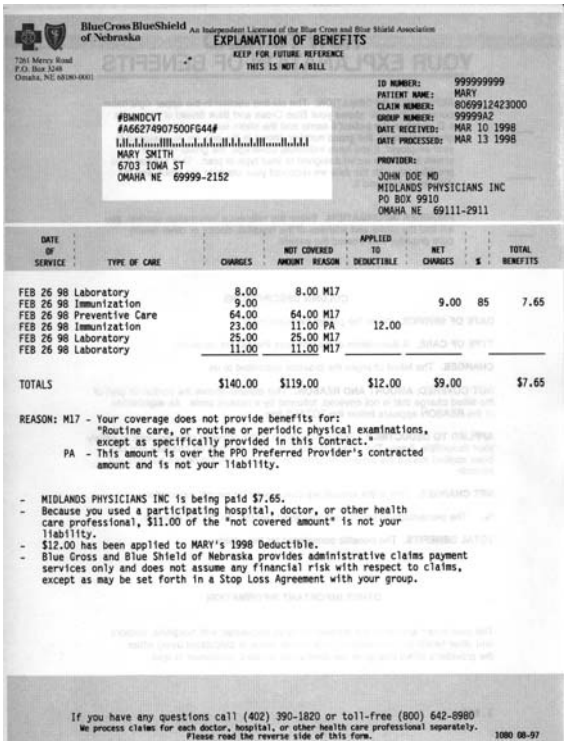
Explanation Of Benefits

Every time a claim is processed for you, an Explanation of Benefits (EOB) form will be sent to you. This summary tells you:

- Type of service.
- Date of service.
- Name of provider of care.
- Charges.
- Charges applied toward your deductible or coinsurance.
- Noncovered charges with explanation.
- Benefits paid by other insurance.
- Other explanatory notes.

Also included on your Explanation of Benefits is information regarding your right to appeal a benefit determination.

Save your Explanation of Benefits forms in the event that you need them for other insurance or for tax purposes.



BlueCross BlueShield of Nebraska
An Independent Licensee of the Blue Cross and Blue Shield Association

EXPLANATION OF BENEFITS
KEEP FOR FUTURE REFERENCE
THIS IS NOT A BILL

7261 Mercy Road
P.O. Box 3248
Omaha, NE 68180-0001

#BWNDCVT
#A6627490750OFG44#
MARY SMITH
6703 IOWA ST
OMAHA NE 69999-2152

ID NUMBER: 999999999
PATIENT NAME: MARY
CLAIM NUMBER: 8069912423000
GROUP NUMBER: 99999A2
DATE RECEIVED: MAR 10 1998
DATE PROCESSED: MAR 13 1998

PROVIDER:
JOHN DOE MD
MIDLANDS PHYSICIANS INC
PO BOX 9910
OMAHA NE 69111-2911

DATE OF SERVICE	TYPE OF CARE	CHARGES	NOT COVERED AMOUNT	REASON	APPLIED TO DEDUCTIBLE	NET CHARGES	%	TOTAL BENEFITS
FEB 26 98	Laboratory	8.00	8.00	M17				
FEB 26 98	Immunization	9.00				9.00	85	7.65
FEB 26 98	Preventive Care	64.00	64.00	M17				
FEB 26 98	Immunization	23.00	11.00	PA	12.00			
FEB 26 98	Laboratory	25.00	25.00	M17				
FEB 26 98	Laboratory	11.00	11.00	M17				
TOTALS		$140.00	$119.00		$12.00	$9.00		$7.65

REASON: M17 - Your coverage does not provide benefits for: "Routine care, or routine or periodic physical examinations, except as specifically provided in this Contract."
PA - This amount is over the PPO Preferred Provider's contracted amount and is not your liability.

- MIDLANDS PHYSICIANS INC is being paid $7.65.
- Because you used a participating hospital, doctor, or other health care professional, $11.00 of the "not covered amount" is not your liability.
- $12.00 has been applied to MARY's 1998 Deductible.
- Blue Gross and Blue Shield of Nebraska provides administrative claims payment services only and does not assume any financial risk with respect to claims, except as may be set forth in a Stop Loss Agreement with your group.

If you have any questions call (402) 390-1820 or toll-free (800) 642-8980
We process claims for each doctor, hospital, or other health care professional separately.
Please read the reverse side of this form.
1080 08-97

Appeal Procedures

Blue Cross and Blue Shield of Nebraska has the discretionary authority to determine eligibility for benefits under the group health and dental plan, and to construe and interpret the terms of the plan, consistent with the terms of the master group contract.

You have the right to seek and obtain a review of any determination made regarding claims, benefit availability, or other complaint arising under this group health and dental plan. This includes decisions made by Utilization Review, and those concerning preadmission certification and concurrent review.

First Level Appeal

If you disagree with the determination made on a claim, you may submit an appeal. A request for a first-level appeal must be submitted in writing within one year of the date the claim was processed. The letter must state that it is a request for an appeal, and if possible, include a copy of the Explanation of Benefits (EOB). The appeal should include:

- a general description of the appeal;
- the name of the covered person;
- Blue Cross and Blue Shield of Nebraska I.D. number;
- the date of service and claim number, if any; and
- any additional information that might help resolve the matter.

The written appeal should be sent to

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, Nebraska 68180-0001

Written decisions for claim appeals will be provided within 30 working days.

An expedited review may be requested for an appeal of an urgent care claim denial, or if the time frame for a standard review would seriously jeopardize the life or health of the covered person. An expedited review decision will be made within 72 hours of receipt of the request, and written confirmation will be sent not later than three days after the oral notification. A request for an expedited review of a concurrent care denial must be made within 24 hours of the initial denial.

Notification of the Appeal Decision - A written notice of the appeal determination will be provided to you (the claimant). If the appeal determination is adverse, this written notice shall include the reasons for the decision, a reference to the contract provisions upon which the decision is based, a description of the second level review process and your rights to further action or appeal. An explanation of the clinical rationale used in making the decision will be provided to the claimant, free of charge, upon written request.

If the appeal involves medical judgment, Blue Cross and Blue Shield of Nebraska will consult with appropriate medical personnel in order to make the appeal determination. Identification of the medical personnel consulted during the appeal process, if any, will be provided upon written request. The appeal determination shall be made by individuals who were not involved in the original decision.

Second Level Appeal

If you are not satisfied with the first level appeal decision, a second level appeal may be submitted. It must be submitted within six months of receipt of the notice of the first level appeal decision. The letter must be mailed to:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, Nebraska 68180-0001

A second level appeal decision will be made within 30 days of the request. A second level urgent care appeal will be completed in a time frame that is reasonable under the circumstances.

No deference will be given to either the initial determination or the first level appeal. The claimant will be provided with a written notification of the appeal decision, as described above.

Legal Actions

You must exhaust the first and second levels of appeal stated above prior to filing a lawsuit. A lawsuit may not be filed less than 60 days after the claim is filed; nor more than three years from the time the claim is required to be filed.

Definitions

ALLOWABLE CHARGE: The allowable charge for a covered service provided by a dentist or other licensed professional provider is the lower of the billed charge, the reimbursement schedule amount if by a BluePreferred Nebraska dentist, or the maximum benefit amount. The allowable charge for any other covered service is the billed charge.

ANNUAL ENROLLMENT MONTH: The month during which membership additions and deletions are made. This month usually corrsponds to the rating anniversary and must be mutually agreed upon by the group applicant and Blue Cross and Blue Shield of Nebraska.

APPROVED PROVIDER: A licensed practitioner of the healing arts who provides covered services within the scope of his or her license and who is payable pursuant to Nebraska statutes and/or the direction of Blue Cross and Blue Shield of Nebraska's Board of Directors.

COINSURANCE: The amount (percentage) of each allowable charge which the covered person must pay after application of any applicable deductible amount.

CONSULTATION: Dental services for a covered person in need of specialized care requested by the attending dentist who does not have that knowledge.

CONTRACT: The agreement between Blue Cross and Blue Shield of Nebraska and the applicant (group providing dental coverage).

COSMETIC: Services, procedures, surgery and any supplies provided to improve the patient's physical appearance, while not materially improving the patient's essential bodily functions, regardless of emotional or psychological factors.

COVERED PERSON: You and/or your eligible dependents who are enrolled for coverage under this group dental care plan.

COVERED SERVICE: Dental procedures, supplies, or other dental care services provided under this group dental care plan to a covered person while coverage is in effect.

DEDUCTIBLE: An amount payable by the covered person each calendar year for covered services before benefits are payable by this group dental plan.

DENTIST: Practitioner of Dentistry as defined in Nebraska Revised Statutes Sections 71-183 et seq.

ELIGIBLE DEPENDENT:

1. The spouse of the Subscriber unless the marriage has been ended by a legal, effective decree of dissolution, divorce or separation.

2. Unmarried children 18 years of age or less who are dependent on the Subscriber for support and maintenance.

   A child is dependent so long as he or she:

   - lives with the Subscriber, or
   - is provided financial support (voluntarily or by order of the court), or
   - is provided health coverage by order of the court

   "Child" means the Subscriber's biological and adopted child, or a child under a court-appointed guardianship, but does not include a foster child. "Child" includes a grandchild who lives with the Subscriber in a regular child-parent relationship if the Subscriber has been appointed by the court as the child's legal guardian. "Child" also includes a stepchild who both lives with the Subscriber and is chiefly dependent on the Subscriber for support and maintenance.

3. Unmarried dependent children (students) 23 years of age or less for whom the Subscriber provides support and who are in full time attendance at an educational institution which has a curriculum, faculty and student body in attendance. Coverage will continue during normal school vacation periods.

4. Reaching age 19, or if a full-time student, age 24, will not end the covered child's coverage under this Contract as long as the child is, and remains, both:

   a. incapable of self-sustaining employment, or of returning to school as a full-time student, by reason of mental or physical handicap, and

   b. dependent upon the Subscriber for support and maintenance.

   Proof of the requirements of paragraphs a. and b. from the Subscriber must be received within 31 days of the child's reaching age 19 (or if a full-time student, age 24) and after that, as required (but not more often than yearly after two years of such handicap). Determination of eligibility under this

provision will be made by Blue Cross and Blue Shield of Nebraska. Any extended coverage under this paragraph 4. will be subject to all other provisions of the Contract.

EMPLOYEE: An individual hired by an employer who enrolls for coverage under this group dental plan, and who is named on an identification card issued by Blue Cross and Blue Shield of Nebraska.

EMPLOYER: A group applicant who signs the Master Group Application for dental coverage on behalf of its employees.

GROUP APPLICANT: The employer making application for coverage under this Master Group Contract.

ILLNESS: Bodily disorder or disease.

INJURY: Accidental physical harm.

INVESTIGATIVE: Treatment is considered investigative when the service, procedure, drug or treatment modality has progressed to limited human application, but has not been generally recognized as being proven and effective in clinical medicine.

Such recognition may be achieved through the following:

- Final approval for the use of a specific service, procedure, drug or treatment modality for a specific diagnosis from the appropriate governmental regulatory body; or
- Scientific evidence permitting a consensus of opinion recognizing the effectiveness of the specific service, procedure, drug or treatment modality on health outcomes for a specific diagnosis.

A specific service, procedure, drug or treatment modality will be considered investigative:

- if reliable evidence shows the specific drug, service, procedure or treatment modality is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- if reliable evidence shows that the consensus of opinion among experts regarding the drug, service, procedure or treatment modality is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence will mean only published reports and articles in the authoritive medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same specific drug, service, procedure or treatment modality.

Blue Cross and Blue Shield of Nebraska will determine whether a service, procedure, drug or treatment modality is investigative.

MASTER GROUP APPLICATION: A form provided by Blue Cross and Blue Shield of Nebraska, executed by the group applicant, and accepted by Blue Cross and Blue Shield of Nebraska which becomes part of this Master Group Contract.

MAXIMUM BENEFIT AMOUNT: A benefit amount which is the amount determined by Blue Cross and Blue Shield of Nebraska to be reasonable. The maximum amount will be the amount agreed upon between Blue Cross and Blue Shield of Nebraska and participating professional providers for the covered service. If no amount has been established for a covered service, Blue Cross and Blue Shield of Nebraska may consider the charges submitted by providers for like procedures, a relative value scale which compares the complexity of services provided, or any other factor deemed necessary.

MEDICAID: Grants to states for Medical Assistance Programs, Title XIX of the Social Security Act, as amended.

MEDICALLY NECESSARY: Services, procedures or supplies provided by the dentist, or other health care provider, in the diagnosis or treatment of the covered person's illness, injury or pregnancy, which are:

- Appropriate for the symptiom’s and diagnosis of the patient’s illness, injury or pregnancy; and
- Provided in the most appropriate setting and at the most appropriate level of services. The most appropriate setting and most appropriate level of services is that setting and that level of services which is the most cost effective without adversely affecting the covered person’s medical or dental condition; and
- Consistent with prevailing professionally recognized standards in the jurisdiction where the service is performed; and

- Not provided primarily for the convenience of any of the following:

  the covered person;
  the dentist or physician;
  the covered person's family; or
  any other person or health care provider.

- Not considered to be unnecessarily repetitive when performed in combination with other diagnoses or treatment procedures.

Blue Cross and Blue Shield of Nebraska will determine whether services provided are medically necessary. Services will not automatically be considered medically necessary because they have been ordered or provided by a physician or dentist.

MEDICARE: Health Insurance for the Aged and Disabled, Title XVIII of the Social Security Act, as amended.

NONCOVERED PERSON: A person who is not covered under this group dental plan, and for whom benefits are not available.

NONCOVERED SERVICES: Hospital, medical or dental services, supplies, home medical equipment, drugs or other health care services, for which this group dental plan does not provide benefits. (Noncovered services are the financial responsibility of the covered person.)

NON-PARTICIPATING: A provider who has not contracted with Blue Cross and Blue Shield of Nebraska to provide services.

PARTICIPATING PROVIDER: A licensed practitioner of the healing arts, or qualified provider of health or dental services and supplies who has contracted with Blue Cross and Blue Shield of Nebraska.

PHYSICIAN: Any person holding an unrestricted license and duly authorized to practice medicine and surgery.

PREAUTHORIZATION (OR TREATMENT PLAN): A prior written approval by Blue Cross and Blue Shield of Nebraska of benefits for certain covered services. This preauthorization is based on the terms of this group dental plan and is based on the information submitted to Blue Cross and Blue Shield of Nebraska and may be effective for a limited period of time.

PREFERRED PROVIDER: A licensed dentist or licensed practitioner of the healing arts, or qualified provider of health and dental services or supplies who has contracted with Blue Cross and Blue Shield of Nebraska as part of the BluePreferred Provider Network (formerly PPO Nebraska).

SCHEDULE OF BENEFITS: A summarized personal document which provides information about deductibles, coinsurance, special benefits, maximums and limitations of the group dental plan. It also indicates the type of Membership Unit selected and whether or not waiting periods are in effect.

UTILIZATION REVIEW: The evaluation by Blue Cross and Blue Shield of Nebraska of the use of a dental, medical, diagnostic or other procedure or service, or the utilization of dental supplies compared with criteria established by Blue Cross and Blue Shield of Nebraska in order to determine benefits.