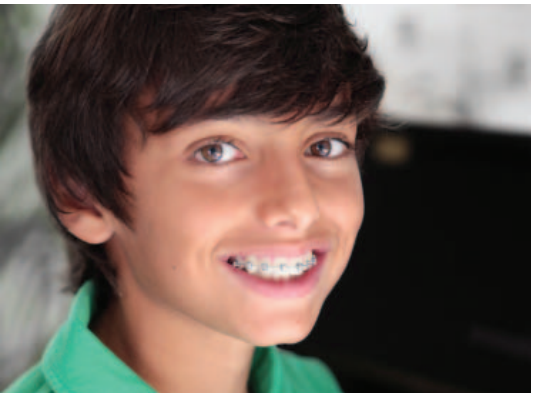

A Guide to Your Dental Benefits

Educators Health Alliance (EHA)

Option 3

(Effective Date: 09/01/2016)

NEBRASKA

98-442 1/2011

IMPORTANT TELEPHONE NUMBERS

Member Services
Omaha and Toll-free 1-888-592-8961
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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INTRODUCTION

Welcome

This document is your Certificate of Coverage. It has been written to help you understand your group dental coverage with Blue Cross and Blue Shield of Nebraska (BCBSNE), an independent licensee of the Blue Cross and Blue Shield Association.

This Certificate of Coverage is only a partial description of the benefits, exclusions, limitations, and other terms of the Master Group Dental 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 Dental Contract controls the coverage for your group.

The Master Group Dental Contract is made in and governed by the laws of the State of Nebraska. Please note that this Certificate of Coverage may not list all the benefits provided by the laws of your state if you do not reside in Nebraska. Please read this Certificate of Coverage carefully.

Please share the information found in this Certificate of Coverage with your Eligible Dependents. Additional copies of this document or your Schedule of Benefits are available from the BCBSNE Member Services Department. If you have a question about your coverage or claim, please contact BCBSNE Member Services at the number shown on your identification card.

How To Use This Document

For your convenience, defined terms are capitalized throughout this document. For an explanation of a defined term, refer to the Section titled "Definitions."

Please take some time to read this document and become familiar with it. We especially encourage you and your Eligible Dependents to review the benefit limitations by reading the Schedule of Benefits Summary.

As you read this Certificate of Coverage you will find that many of the sections of the document are related to other sections of the document. You may not have all the information you need by reading just one section. If, after reading this Certificate of Coverage you have questions about the coverage available to you, you should call BCBSNE Member Services.

About Your I.D. Card

BCBSNE will issue you an identification card (I.D. card). Your I.D. number is a unique alpha numeric combination.

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 BCBSNE I.D. card, most dentists 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 BCBSNE Member Service Department. Remember, only persons who are eligible for coverage under your membership may use your BCBSNE I.D. card.

What's A Schedule Of Benefits?

Your Schedule of Benefits is a personalized document that provides you with a basic overview of your coverage. It also shows the membership option that applies to you.

This document provides a general description of coverage. For additional information which may be unique to your coverage, please refer to the Schedule of Benefits Summary.

THE DENTAL PLAN AND HOW IT WORKS

Section 1

About The Plan

This Group Dental Plan is a Blue Cross and Blue Shield of Nebraska (BCBSNE) Preferred Provider Organization (PPO) dental benefit plan.

The PPO (In-network) Provider network was established by BCBSNE through contracts with a panel of Dentists and Physicians who have agreed to furnish services to you and your family in a manner that will help manage costs. These providers are referred to as "In-network Providers."

Use of the network is voluntary, but you should be aware that when you choose to use providers who do not participate in the network, you can expect to pay more than your applicable Deductible and/or Coinsurance. After this dental plan pays its required portion of the bill, Out-of-network Providers may bill you for any amount not paid. This balance billing does not happen when you use In-network Providers because these providers have agreed to accept a discounted payment for services with no additional billing to you other than your applicable Deductible and/or Coinsurance. In-network Providers will also file claims for you.

If the Out-of-network Dentist is participating with us under another BCBSNE program, payment will be made pursuant to that particular program. The Dentist will be reimbursed based on the lower of the Out-of-network Allowance or billed charges. After this plan pays its liability, you can expect to pay your applicable Out-of-network Deductible and/or Coinsurance. You will also be responsible for payment of any Noncovered Services.

Using Your Benefits Wisely

BCBSNE wants you to get the most from your group dental coverage.

As you read this document, some "Good Care tips" will be highlighted in boxes just like this one.

How the Network Works

Using Network Providers:

- Receive highest level of benefits
- Provider files claims for you
- Provider accepts insurance payment as payment in full (except Deductible, and /or Coinsurance amounts)
- No balance billing

Using Out-of-network Providers:

- You may be required to pay full cost at time of service
- You may be reimbursed at a lower benefit level
- You may have to file claims
- You're responsible for amounts that exceed the Allowable Charge

Be Informed

Out-of-network Providers' charges may be higher than the benefit amount allowed by this dental plan. You may contact BCBSNE Member Services Department concerning allowable benefit amounts in Nebraska for specific dental procedures.

Categories Of Dental Coverage

There are five major categories of dental coverage. Your dental coverage is dependent upon which types of coverage your employer has chosen for your group dental plan. The types of dental coverage that you are enrolled under are indicated on your Schedule of Benefits Summary and they are specified within your plan's Master Group Dental Contract.

The five categories of dental coverage are:

- Coverage A (Preventive and Diagnostic Dentistry)
- Coverage B (Maintenance and Simple Restorative Dentistry, Oral Surgery, Periodontic and Endodontic Services)
- Coverage C (Complex Restorative Dentistry)
- Coverage D (Orthodontic Dentistry)
- Coverage E (Temporomandibular [Jaw] Joint Diagnosis and Treatment)

These categories are described in more detail on your Schedule of Benefits Summary.

The dental benefits available to you work together to provide your dental care program. How benefits are provided depends on whether the dental service or treatment falls under Type A, B, C, D or E coverage.

How The Plan Components Work

Your Deductible, Coinsurance and Coinsurance Limit are shown on your Schedule of Benefits Summary. The following includes an explanation of each of those components.

Allowable Charge – An amount BCBSNE uses to calculate the payment of Covered Services. This amount will be based on either the Contracted Amount for In-network Providers or the Out-of-network Allowance for Out-of-network Providers.

Coinsurance – Your Schedule of Benefits Summary will tell you if Coinsurance is applicable to one or more of the different types of dental coverage. This is the percentage you must pay for Covered Services, less any applicable Deductible, based on the lesser of the Allowable Charge or the billed charge. (Your Coinsurance is generally lower if you receive Services from an In-network Provider.)

Deductible –Your Schedule of Benefits Summary will tell you if you have a Deductible on one or more of the different types of dental coverage. The Deductible is an amount of Allowable Charges that must be met before benefits begin. When a calendar year Deductible is mentioned, keep in mind that only one applies in any calendar year even though you may have several trips to your dentist during that year.

Maximum Benefits –Your Schedule of Benefits Summary will tell you if you have a benefit maximum for one or more types of dental coverage and/or an overall dollar maximum benefit for one or more types of dental coverage.

Not Medically Necessary Services – Benefits are available under this dental plan for Medically Necessary Services. Services provided by all providers are subject to review by BCBSNE. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Dentist or Physician. BCBSNE will determine whether Services provided are Medically Necessary under the terms of the Group Dental Plan, and whether benefits are available. When an In-network Provider is used, you are not responsible for Services determined to be not Medically Necessary. When Out-of-network Providers are used, you will be responsible for Services determined to be not Medically Necessary.

Certification – Certification procedures are intended to determine if Services or supplies are appropriate according to the terms of the Group Dental Plan. Certain surgical procedures, specialized Services and Services may require Certification of benefits. A provider may initiate the Certification; however, you are ultimately responsible for making sure Certification occurs.

If Services are not properly Certified by BCBSNE, payable benefits may be reduced and/or you may be responsible for unanticipated costs associated with the incurred expenses.

For Services that require Certification, please refer to the section of this document titled "Certification Requirements."

SCHEDULE OF BENEFITS SUMMARY

Section 2

Payment for Services	In-Network Provider	Out-of-Network Provider
Covered Services are reimbursed based on the Allowable Charge. BlueCross and BlueShield of Nebraska In-Network Providers have agreed to accept the benefit payment as payment in full, not including deductible, coinsurance and/or copay amounts and any charges for non-covered services, which are the Covered Person's responsibility. That means that In-Network providers, under the terms of their contract with BlueCross and BlueShield, can't bill for amounts over the Contracted Amount. Out-of-Network Providers can bill for amounts over the Out-of-Network Allowance.		
Deductible (the amount the Covered Person pays each Calendar Year for combined Covered Services before the Coinsurance is payable) • Individual • Family Calendar Year Deductible applies to the following Coverage benefits:	 **$0** **$0** **A, B, C Services**	 **$0** **$0** **A, B, C Services**
Coinsurance (the percentage the Covered Person must pay after Deductible)		
Coverage A	**20%**	**20%**
Coverage B	**20%**	**20%**
Coverage C	**20%**	**20%**
Coverage D	**Not Covered**	**Not Covered**
Coverage E	**Not Covered**	**Not Covered**

Coverage For Dental Services

Coverage A – Preventive and Diagnostic

- **Comprehensive and/or periodic oral exams**
  two every calendar year
- **Prophylaxis (cleaning, scaling and polishing)**
  two every calendar year

Coverage B – Maintenance

- **Simple and impacted extractions**
- **Bitewing x-rays**
- **Silver amalgam fillings** (if other filling material is used, payment is limited to the amount payable for silver amalgam)
- **Temporary crown (within 72 hours of accident)**
- **Topical fluoride**
- **Repair of dentures (limited to $25 per calendar year)**
- **Space maintainers**
  for Covered Persons up to age 16
- **Pulpotomy**
  for Covered Eligible Dependent Children up to age 16
- **Stainless steel crowns (limited to diseased or damaged teeth)**
- **Recement inlays and crowns (limited to diseased or damaged teeth)**
- **Palliative treatment (limited to opening and draining of a tooth when no treatment follows; or smoothing down a chipped tooth)**
- **Initial application of sealants (limited to first of second molars)**
  for Covered Eligible Dependent Children between age 6 and age 16; reapplication every four years

Coverage C – Complex Restorative Dentistry

- **Crowns and inlays**
- **Installation of permanent bridges**
- **Endodontics (pulpotomy, pulp capping and root canal treatment)**
- **Oral Surgery consisting of fracture and dislocation treatment**
- **Diagnosis and treatment of cysts and abscesses**
- **Dentures – full and partial**
- **Denture adjustments**
  beginning after six months from date of installation
- **Denture relining**
  one every 36 consecutive months
- **Periodontics**
  - Surgical periodontic eamination
  - Gingival curettage
  - Gingivectomy and gingivoplasty
  - Osseous surgery
  - Mucogingivoplastic surgery
  - Treatment of acute infection and oral lesions

Coverage D – Orthodontic Dentistry (NOT COVERED)

- **Cephalometric x-rays**
- **Extractions**
- **Casts and models**
- **Orthodontic appliances** *(initial and subsequent installations)*
- **Surgical exposure to aid eruption**

Coverage E – Temporomandibular Joint Diagnosis and Treatment (NOT COVERED)

- **Treatment for occlusal equilibration** *(grinding of teeth)*
- **Open and closed operative procedures**
- **TMJ x-rays**
- **Initial and subsequent installation of appliances and treatment**

CERTIFICATION REQUIREMENTS

Section 3

Certification Process

BCBSNE Certification procedures are intended to determine if Services or supplies are appropriate under the terms of the plan.

In order to avoid unanticipated costs, surgical procedures and specialized Services and supplies must be Certified by BCBSNE. The Subscriber is responsible for making sure Certification occurs.

To initiate the Certification process, BCBSNE must be contacted by you, your family member, or a person or facility acting on behalf of you or your family member. Notification of the intended receipt of Services may be made by telephone or in writing. We may require that the Certification include written documentation from the Covered Person's Physician, Dentist or other medical provider demonstrating the Medical Necessity of the procedure or Service and the location where the Service will be provided.

Please remember that Certification does not guarantee payment. All other group plan provisions apply. For example: Copayments, Deductibles, Coinsurance, eligibility and exclusions.

Benefits Requiring Certification

Certain procedures or Services under the following coverage types may require Certification:

- Coverage B
- Coverage C
- Coverage D
- Coverage E

If your plan includes any of the coverage types listed above, be sure Certification is obtained prior to receiving services.

Unanticipated Costs

Failure to follow the Certification requirements may result in unanticipated costs associated with the incurred expenses.

If Services are not properly Certified and benefits are reduced or denied, this unanticipated reduction becomes an additional amount that must be paid by you. Any reductions made are not considered when computing your Coinsurance liability limit.

EXCLUSIONS—WHAT'S NOT COVERED

Section 4

Although this dental plan provides benefits for a wide variety of Services, there are some expenses that are not covered. This section gives you examples of Services and supplies that may not be covered. **However, there may be items listed below that your dental plan covers. Your Schedule of Benefits Summary, and any amendment to this document, identifies the categories of dental coverage and whether or not you have benefits for each coverage type.**

Benefits are not available for Services that are not Covered Services as described in your plan's Master Group Dental Contract, or Services to the extent that they exceed the limitations stated in your plan's Master Group Dental Contract.

Noncovered Dental Services

The Services, procedures or supplies listed as exclusions in this section are not covered, except when specifically provided for on your Schedule of Benefits Summary or by an amendment to this document. Noncovered Services include, but are not limited to, any Services, procedures or supplies for, or related to:

- 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 (including, but not limited to missing teeth) or primarily for Cosmetic or aesthetic purposes (except as specifically identified as Covered.) Gnathologic tests, Orthognathic Surgery, osteoplasties, Osteotomies, LeFort procedures, vestibuloplasties and stomatoplasties are not Covered Services under this plan.
- 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 (except as specifically identified as covered.)
- Gold restorations (except as specifically identified as covered.)
- Full or partial replacement for:
  - A denture replacement made necessary by reason of the loss or theft of a denture.
  - A dental appliance or prosthesis that is replaced by reason of a loss or theft.
  - Crown, bridge, inlay and denture replacement made outside the plan limits.
- Caries susceptibility tests, bacteriologic studies and histopathologic exams.
- Magnetic resonance imaging and computed tomography (CT) scans.
- Replacement of third molars with prostheses.
- Services for orthodontic dentistry (except as specifically identified as covered.)
- Education or training in, and supplies used for dietary or nutrition counseling, person oral hygiene or dental plaque control.
- Implants or any procedure associated with the preparation for, maintenance of or placement or removal of implants, except as otherwise indicated in this plan. (Implants are defined as artificial material grafted or implanted into or onto bone.)
- For any procedure begun after coverage under this plan terminates or for any prosthetic dental appliance installed or delivered more than 30 days after coverage terminates.
- 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 determined by us not to be adequate to meet nationally accepted dental standards.
- Duplication of x-rays.

Plan Exclusions

Except when specifically provided for on your Schedule of Benefits Summary or by amendment to this document, benefits are not available for the Services, treatments or supplies described in this section, even if it is recommended or prescribed by a Physician and it is the only treatment available for the Covered Person's condition.

- Services determined by BCBSNE to be not payable after a request for Certification is considered.
- Services, procedures and supplies which are determined by BCBSNE to be not Medically Necessary.
- Services, procedures and supplies which are considered by BCBSNE to be Investigative. In addition, benefits are not available for any related services or complications.
- Services, procedures or supplies, including any related services, which are considered to be for Cosmetic purposes.
- Services, procedures or supplies, including any related services, which are considered by BCBSNE to be obsolete.

- Charges which are normally considered to be within the charge for a service such as:
  - filing claim forms,
  - furnishing any other records or information,
  - special charges (i.e. dispensing fees; administrative fees; technical support utilization review charges).
- Missed appointment charges.
- Services provided to:
  - A 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.
- Interest, sales or other taxes or surcharges. (This includes taxes or surcharges levied by the governmental bodies or subdivisions who do not have jurisdiction over the plan's Master Group Contract.)
- 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 Out-of network Hospital or other institution or facility which is owned, operated or controlled by any government agency, except where care is provided to nonactive duty Covered Persons in medical facilities.
- Services available at governmental expense (except Medicaid) whether or not the person has enrolled in the program.
- Services for which there is no legal obligation to pay, or for which no charge would be made if this coverage did not exist including any service which is normally furnished without charge.
- Services arising out of or in the course of employment, whether or not the Covered Person asserts his or her rights to workers' compensation or employers' liability law. (This includes services determined to be work-related but which are not payable because of noncompliance with workers' compensation laws or a workers' compensation managed care plan.)
- 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.
- Charges made separately for services, supplies or materials when such services, supplies and materials are considered by BCBSNE to be included within the charge for a total service payable under the Contract, or a charge that is payable to another provider.
- Charges made pursuant to an intentionally inflicted Injury, engaging in an illegal occupation or resulting from commission of or attempt 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.
- Charges for services provided by a Hospital, ambulatory surgical facility or any other facility charge.
- Any expense for a procedure provided by a person who is not a Dentist or dental hygienist or who is not under the direct supervision of a Dentist.
- Injectable drugs or drugs dispensed in a provider's office.

Limitations

The following limitations are applicable except when otherwise indicated on your Schedule of Benefits Summary or by amendment to this document:

- Personalized restoration or special techniques. Benefits provided in the construction of a denture or fixed bridgework to replace missing teeth shall be limited to the standard procedures for prosthetic services as determined by BCBSNE.
- Transfer of care. When a Covered Person transfers care during the course of treatment, or if more than one Dentist provides services, this plan will provide benefits as if only one dentist has provided the service.
- Optional techniques of treatment. When optional techniques of treatment are used which result in a higher charge, the plan's liability will not exceed the lower charge.
- Exam limit. When an initial or periodic oral exam is performed during the same visit, benefits for exams shall be limited to one exam per day.

Limited Extension of Dental Benefits

(Applicable to Dental Coverage Types B, C and D)

A Covered Person may be entitled to extended benefits for Covered Services up to 30 days after termination of coverage under this Group Dental Plan for:

- root canal therapy, but only if the pulp chamber was opened and the pulp canal explored to the apex while the person was covered under this plan;
- crowns, bridges, inlays or onlay restorations, but only if the tooth or teeth were fully prepared while the person was covered under this plan;
- full or partial denture, but only if the master impression was made while the person was covered under this plan; and
- orthodontia, but only if the appliance or bands were first set while the person was covered under this plan. The amount payable will be the part of the quarterly payment that would have been payable had coverage remained in force during this period.

Limited Extension Ends - This extended coverage ceases on the earlier of:

- the end of the 30-day extension period; or
- the date the person becomes eligible for such services under another Group Dental Plan.

Please check with your employer regarding whether this limited extension of benefits is available to you.

For group specific eligibility and enrollment provisions, including information, when applicable, on initial enrollment, special enrollment, late enrollment, open enrollment and adding a dependent, please refer to the amendment in the back of this book.

Who's Eligible

The Plan's eligibility requirements are specified in the Master Group Contract between BCBSNE and your employer. We refer to the individual who enrolls for the coverage or the "employee" as a Subscriber. Dependents are generally your spouse and children; however, in order to be an Eligible Dependent, they must meet the definition of an Eligible Dependent.

For group specific eligibility requirements, please refer to the amendment in the back of this book.

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 unit.

Qualified Medical Child Support Orders (QMCSO)

A 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 receive plan information, submit claims and receive benefits for services.

QMCSOs 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 Age 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 the group plan is elected as the primary carrier (the plan which pays first), Medicare becomes the secondary coverage. If Medicare is elected as the primary carrier, coverage under the group plan, including dental coverage, will be terminated. This law applies to employers with 20 or more employees. Please check with your employer regarding whether your group is subject to this federal law.

Family Medical Leave Act (FMLA)

The Family Medical Leave Act of 1993, as amended, requires that subject to certain limitations, most employers of 50 or more persons must offer continued coverage to eligible employees and their covered dependents, while the employee is on an approved FMLA leave of absence. In addition, an employee who has terminated his/her group dental coverage while on an approved FMLA leave is entitled to reenroll for group dental coverage upon return to work. Please check with your employer for details regarding your eligibility under FMLA.

If You Receive Covered Services From An In-network Provider

If you receive services from a Dentist or other health care provider who is contracting with BCBSNE, the claim will be filed directly by them. To expedite claims filed by your dental care providers, please be sure they are given the following information:

- Correct I.D. number.
- The exact date and time of an accident if applicable, and whether or not it occurred at work.
- The name and I.D. number of any other dental insurance.

Filing A Claim

You must file your own claim if your dental care provider is not a Contracting Provider and does not file for you. You can obtain a claim form by contacting BCBSNE's Member Services Department, or you can find a form on the website: www.nebraskablue.com.

Listed below are some helpful claim filing hints:

- Complete the appropriate dental claim form in full. (Be sure the I.D. number, including the alpha prefix, is correct.)
- Complete a separate dental claim form for each eligible family member.
- File your dental claims as soon as possible. Claims should be filed within 90 days after services are provided.
- Complete each section of the claim form. If a section doesn't apply, write "not applicable." Don't leave any sections blank or your dental claim may be returned for the missing information.
- Give the exact date and time of an accident (if applicable) and whether or not it occurred at work.
- Always attach the original, itemized dental bill to your dental claim form. The dental bill must be on the letterhead stationery or billing form of the provider. Itemized bills must include: a description of the service, the diagnosis, amount charged for the care and the provider's full name and credentials.
- The primary plan's explanation of benefits (EOB), if applicable.
-

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 within the claim filing limit (normally within 15 months of the date of service unless otherwise specified by an amendment to this document), benefits will not be allowed. Claims, including revisions, that are not filed by a BCBSNE In-network Provider prior to the claim filing limit, will become the provider's liability.

Claim forms should be sent to:

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

If you need assistance with filing your claim, please contact BCBSNE's Member Services Department.

Payment Of Benefits For Non-Contracting Provider Claims

Payment will be made, at BCBSNE's option, to the Covered Person, to his or her estate, to the provider or as required by state or federal law. Benefits may also be paid to an alternate recipient or custodial parent, if pursuant to a QMCSO.

No assignment, 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 BCBSNE, unless otherwise provided by state or federal law.

Claim Determinations

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

Pre-Service Claims — In some cases, under the terms of the Group Dental Plan, the Covered Person is required to certify benefits in advance of a Service being provided, or benefits for the Service may be reduced or denied. This required request for a benefit is a "pre-service" claim." Pre-service claim determinations that are not Urgent Care Claims will be made with 15 calendar days of receipt, unless an extension is needed to obtain necessary information. If additional information is requested, the Covered Person or his or her provider may be given up to 45 calendar days from receipt of notice to submit the specified information. A claim determination will be made within 15 days of receipt of the information, or the end of the 45 day extension period.

(See the section of this book titled "Certification Requirements" for more information on certifying benefits.)

Urgent Care — If your pre-service claim is one for Urgent Care, the determination will be made within 72 hours of receipt of the claim, unless further information is needed. If additional information is necessary, the Covered Person or his or her provider will be given no less than 48 hours to provide the specified information. Notification of the decision will be provided not later than 48 hours after the earlier of: our receipt of the information, or the end of the period allowed to submit the information.

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 instructions for filing a post-service claim are outlined earlier in this section. 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 may be given not less than 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 extension period. You will receive an EOB when a claim is processed which explains the manner in which your claim was handled.

Concurrent Care — If you request to extend a course of treatment beyond the care previously approved and it involves urgent care, a decision will be made within 24 hours of the request, if you submitted the request at least 24 hours before the course of treatment expires. In all other cases, the request for an extension will be decided as appropriate for a pre-service and post-service claims.

Explanation Of Benefits

Every time a claim is processed for you, an Explanation of Benefits (EOB) form will be sent. The front page of the EOB provides you with a summary of the payment including:

- The patient's name and the claim number.
- The name of the individual or institution that was paid for the service.
- The total charge associated with the claim.
- The covered amount.
- Any amount previously processed by this plan, or another insurance company.
- The amount(s) that you are responsible to pay the Provider.
- The total Deductible, Coinsurance and/or Copay that you have accumulated to date.
- Other general messages.

A more detailed breakdown of the charges including provider discounts, amount paid and cost sharing amounts (e.g. noncovered charges, Deductible, Coinsurance and Copays) are shown on the back of your EOB.

Also included on your EOB is information regarding your right to appeal a benefit determination.

Save your EOBs in the event that you need them for other insurance or for tax purposes.

APPEAL PROCEDURES

Section 7

BCBSNE has the discretionary authority to determine eligibility for benefits under the health 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 "adverse benefit determinations" arising under this health plan.

Appeal Procedure Definitions

Adverse Benefit Determination: A determination by BCBSNE or its Utilization Review designee, of the denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) of a benefit. This includes any such determination that is based on:

- the application of Utilization Review;
- a determination that the Service is Investigative;
- a determination that the Service is not Medically Necessary or appropriate;
- an individual's eligibility for coverage or to participate in a plan.

An Adverse Benefit Determination also includes any rescission of coverage, which is defined as a cancellation or discontinuance of coverage that has a retroactive effect, except if for failure to timely pay required premiums or contribution for coverage.

Final Internal Adverse Benefit Determination: An Adverse Benefit Determination that has been upheld by BCBSNE, or its Utilization Review designee, at the completion of the internal appeal process as described in this document.

Preservice Claim(s): Any Claim for a benefit under the plan with respect to which the terms of the Contract require approval of the benefit in advance of obtaining medical care, and failure to do so will cause benefits to be denied or reduced.

Postservice Claim(s): Any Claim that is not a Preservice Claim.

Urgent Care Claim: A Claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations:

- could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or
- would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

How To Appeal An Adverse Benefit Determination

A Covered Person or a person acting on his/her behalf (the "claimant") is entitled to an opportunity to appeal initial or final Adverse Benefit Determinations.

First Level Appeal

A request for a first level appeal must be submitted within 6 months of the date the Claim was processed, or Adverse Benefit Determination was made. The written request for an appeal should state that it is a request for an appeal and, if possible, include a copy of the Explanation of Benefits (EOB). The appeal should also include:

- the name of the person submitting the appeal and his/her relationship to the patient;
- the reason for the appeal;
- any information that might help resolve the issue; and
- the date of service/Claim.

The written appeal should be sent to:

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

Preservice or Postservice Claim Appeal: A written notice of the appeal determination will be provided to the claimant as follows:

- Preservice Claims (other than Urgent Care), within 15 calendar days after receipt.
- Postservice Claims, within 30 calendar days after receipt.

Expedited Appeal: When the appeal is related to an Urgent Care Claim, an expedited appeal may be requested. In the case of an expedited appeal, the request may be submitted in writing or orally. All information, including the decision, will be submitted by the most expeditious method available. BCBSNE will make an expedited review decision within 72 hours after the appeal is requested. Written notification of the decision will be sent within the 72-hour period.

Concurrent Care denials must be appealed within 24 hours of the denial. A Concurrent Care denial will be handled as an expedited appeal. If the appeal is requested within the 24-hour time period, coverage will continue for health care services pending notification of the review decision.

NOTE: When an adverse appeal determination involves medical judgment, upon receipt of a written request, the identity of the health care professionals who reviewed the appeal will be provided to the claimant.

Second Level Appeal

If the claimant is not satisfied with the first level appeal determination, a written request for a second level appeal may be submitted within 60 calendar days of receipt of the first level appeal decision. Unless otherwise indicated on the back of the Covered Person's I.D. card, the written request must be mailed to:

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

The Covered Person and/or a representative have the right to appear in person to present the case before an appeal panel appointed by BCBSNE. The panel will include health care professionals with appropriate expertise when the case being reviewed requires a medical judgment. No deference will be given to either the initial determination or the first level review. The second level review and decision will be made by individuals who were not involved in the prior determinations.

Documentation relevant to the Claim and Adverse Benefit Determination(s) can be accessed or copies requested by the claimant. In addition, supporting material may be submitted by the claimant both before and during the appeal process.

Preservice or Postservice Claim Appeal: Upon receipt of a second level appeal, written notification of the decision will be made as follows:

- Preservice Claims, within 15 calendar days after receipt.
- Postservice Claims, within 30 calendar days after receipt.

The second level determination will be considered the Final Internal Adverse Benefit Decision.

External Review

If the claimant has exhausted all levels of internal appeal review, an external review by an Independent Review Organization (IRO) may be requested. The request must be submitted in writing within four months after receipt of the Final Internal Adverse Benefit Determination. (An Adverse Benefit Determination based on an individual's eligibility for coverage or to participate in a plan is not eligible for External Review.)

The request for an External Review may be submitted electronically, by facsimile, or U.S. mail, as stated on the Final Internal Adverse Benefit Determination notice (letter). Request may be e-mailed to DisputedClaim@opm.gov; fax to 202-606-0036; mail to P.O. Box 791, Washington, D.C. 20044.

The IRO and/or BCBSNE shall review the request and will provide the claimant written notification within 5 business days whether the request is eligible for External Review. If the request is not complete, or is not eligible for External Review, the claimant will be notified of the reason for ineligibility, or advised of the information needed to make the request complete.

If the External Review request is eligible, it will be forwarded to the IRO, including documentation and information used to make the initial Adverse of Final Adverse Benefit Determination. If the claimant wishes to submit additional information to the IRO for consideration, they will have 5 business days to do so.

The IRO will provide the claimant with written notification of its decision within 45 calendar days of receipt. No deference shall be given to the prior internal appeal determinations made by BCBSNE.

Expedited External Review: An expedited External Review of an Adverse Benefit Determination for an Urgent Care Claim may be request at the same time a claimant requests an expedited internal first level appeal. However, the claimant must first exhaust the internal appeal process unless BCBSNE agrees to waive this requirement.

An expedited External Review may also be requested following a Final Internal Adverse Benefit Determination, if:

- the Covered Person has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize his/her life, health, or ability to regain maximum function would be jeopardized.
- the Final Internal Adverse Benefit Determination concerns an admission; availability of care; continued stay, or heath care service for which the Covered Person has received emergency services, but has not been discharged from a facility.

The expedited External Review decision will be made by the IRO within 72 hours after receipt of the request.

Once an External Review decision has been made, the Covered Person or his/her representative may not file a subsequent request for an External Review involving the same Adverse Benefit Determination. The decision of the IRO is the final review decision and is binding on BCBSNE and the claimant, except to the extent that federal or state law may provide the claimant with other remedies.

The Nebraska Department of Insurance may be contacted for assistance at any time during the appeal process. Their address and phone number is:

Nebraska Department of Insurance
941 O Street, Suite 400
Lincoln, Nebraska 68508-3969
(402) 471-2201

ERISA Rights

If the Group health plan is subject to ERISA, Section 502(a) of the ACT provides the claimant with the right to bring a civil action. The Group health plan may have other voluntary alternative dispute resolution options. The claimant may contact the local U.S. Department of Labor office and/or the state regulatory agency for information.

COORDINATION OF BENEFITS

Section 8

When You have Coverage Under More Than One Plan

This Plan includes a Coordination of Benefits (COB) provision. This provision establishes a uniform order in which the Plans pay their claims, limits duplication of benefits and provides for transfer of information between the Plans.

When Coordination Of Benefits Applies

COB provisions apply when a Covered Person has coverage under more than one health Plan. The order of benefit determination rules described in this section determine which Plan will pay as the primary Plan without regard to any benefits that might be payable by another Plan.

Definitions

For the purpose of this section, the terms are defined as:

Allowable Expense: A health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical options, recertification of admissions, and preferred provider arrangements.

Closed Panel Plan: A Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent: The parent awarded custody by a court decree or, in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year excluding temporary visitation.

Plan: Any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

a. Plan includes: group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental Plan, as permitted by law.

b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile "no fault" and traditional "fault" contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined in state law; school accident coverage; benefits for non-medical components of long-term care policies; individual coverage including HMO coverage and subscriber contracts; Medicare supplement policies; Medicaid policies; and coverage under other federal governmental Plans, unless permitted by law.

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

Primary Plan: The Plan that will determine payment for its benefits first before those of any other Plan without considering any other Plan's benefits.

Secondary Plan: The Plan that will determine its benefits after those of another Plan and my reduce the benefits so that all Plan benefits do not exceed 100% of the total Allowable Expense.

This Plan: The part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order Of Benefit Determination Rules

1. The Primary Plan pays or provides its benefits according to its terms or coverage and without regard to the benefits under any other Plan.
2. A Plan that does not contain a coordination of benefits provision that is consistent with this Part is always primary unless the provisions of both Plans stated that the complying Plan is primary.
3. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
4. Each Plan determines its order of benefits using the first of the following rules that apply:

Subscriber And Dependent. The Plan that covers the person as the Subscriber is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as a Subscriber, then the order of benefits between the two Plans is reversed so that the Plan covering the person as a Subscriber is the Secondary Plan and the other Plan is the Primary Plan.

Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

For a dependent child whose parents are married or are living together, whether or not they have ever been married, the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan. If both parents have the same birthday, the Plan that has covered the parents the longest is the Primary Plan (birthday rule).

For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married, if a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, That Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, the Plan of that parent's spouse is primary. This rule applies to Plan years beginning after the Plan is given notice of the court decree.

If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the order of benefits shall be determined by the "birthday rule" stated above.

If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the order of benefits shall be determined by the "birthday rule" stated above.

If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial Parent;
- The Plan covering the spouse of the Custodial Parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

For a dependent child covered under more than one Plan of individuals who are not parents of the child, the above provisions shall apply as if those individuals were the parents.

Active Employee, Retired Or Laid-Off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither retired nor laid off, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the first rule (Subscriber and Dependent) can determine the order of benefits.

COBRA Or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as a Subscriber or covering the person as a dependent of a Subscriber is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the first rule (Subscriber and Dependent) can determine the order of benefits.

Longer Or Shorter Length Of Coverage. The Plan that covered the person as a Subscriber longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan. The start of a new Plan does not include a change in the amount or scope of a Plan's benefits; a change in the entity that pays, providers or administers the Plan's benefits; or a change from one type of Plan to another, such as from a single employer Plan to a multiple employer Plan.

If the above rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

Administration Of Coordination Of Benefits

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Plan that pays after the Primary Plan is called the Secondary Plan.

If this Plan is the Primary Plan, there shall be no reduction of benefits. Benefits will be paid without regard to the benefits of any other Plan.

If this Plan is the Secondary Plan, it may reduce its benefits so that the total benefits paid or provided by all Plans for any claim are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health coverage.

Miscellaneous Provisions

If these COB rules do not specifically address a particular situation, we may, at our discretion, relay on the National Association of Insurance Commissioners Coordination of Benefits Model Regulation as an interpretive guide.

To properly administer these COB rules, certain facts are needed. This Plan may obtain or release information to any insurance company, organization or person. Any person who claims benefits under this Plan agrees to furnish the information that my be necessary to apply COB rules and determine benefits.

If another Plan pays benefits that should have been paid under this Plan, this Plan may reimburse the other Plan amounts determined to be necessary. Amounts paid to other Plans in this manner will be considered benefits paid under this Plan and this Plan is released from liability for any such amounts.

If the amount of the benefits paid by this Plan exceeds the amount it should have paid, this Plan has the right to recover any excess from any other insurer, any other organization, or any person to or for whom such amounts were paid, including Covered Persons under this plan.

For group specific information on the date your coverage will terminate, please refer to the amendment in the back of this document.

You and/or your Eligible Dependents may be eligible to continue coverage under the Group Dental Plan as detailed in this section.

Continuation Of Coverage Under The Federal Continuation Law

If you terminate your employment, or if a dependent loses coverage due to certain "Qualifying Events", continued coverage under the Group Dental Plan may be available. Payment for continued coverage under the federal continuation law is at the employee's or dependent's own expense. Please contact your employer for details regarding eligibility.

What Is The Federal Continuation Law?

The Consolidated Omnibus Reconciliation Act (COBRA), is a federal law which provides that a Covered Person who would lose coverage due to the occurrence of a "Qualifying Event", may elect to continue coverage under the Group Dental Plan. A person who is eligible to continue coverage is called a "Qualified Beneficiary." A Qualified Beneficiary also includes a child born to, or placed for adoption with the Covered Person during the period of COBRA coverage. Please share the information found in this section with your Eligible Dependents.

NOTE: To protect your rights under COBRA, please keep your employer informed of your current address.

Termination Of Employment Or Reduction In Hours – COBRA provides that if you should lose coverage due to:

- termination of employment ;
- a lay-off for economic reasons;
- discharge for misconduct (other than gross misconduct); or
- a reduction in work hours

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 of the event. The Plan Administrator will send the Qualified Beneficiaries a COBRA notification within the time period required by law.

Special Provisions — If an employer files Chapter 11 bankruptcy, special provisions regarding COBRA continuation coverage may apply for the retiree or deceased retiree's surviving spouse and dependent children. Please check with your employer for details.

Disability – If a Qualified Beneficiary is determined by the Social Security Administration to have been disabled any time during the first 60 days of COBRA continuation coverage, the COBRA coverage period for the disabled individual and his or her related beneficiaries may be extended to 29 months instead of 18 months when loss of coverage is due to termination or reduction in hours of employment. You must provide written notice of the disability determination to the plan within 18 months of becoming eligible for COBRA 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 period (19th through 29th month) will be terminated the month that begins more than 30 days after the determination. You must notify the plan within 30 days of a determination that an individual is no longer disabled.

Change In Dependent Status, Divorce/Separation Or Medicare Entitlement –If your covered spouse and eligible children would otherwise lose coverage as a result of:

- divorce or legal separation;
- a child losing dependent status, or
- the employee becoming entitled to Medicare,

COBRA requires that they be allowed to continue coverage at their own expense for up to 36 months.

In the case of divorce or legal separation, or a child's loss of dependent status, you or the dependent are obligated to notify the Plan Administrator within 60 days of the later of the event or the date coverage would be lost. The notice must include sufficient information to enable the Plan Administrator to determine the Group Dental Plan to which the notice applies; the covered employee and qualified beneficiary(ies); the qualifying event; and the date the qualifying event occurred. Failure to provide timely and proper notice may result in the loss of the right to COBRA.

After receiving a timely notice of such an event, if eligible, the Plan Administrator will send the Qualified Beneficiary an election form and the information needed to apply for coverage within 14 days of the date the notice is received.

Your Death – If you should die while you are covered under this Group Dental Plan, continued coverage is available to your spouse and Eligible Dependents.

COBRA provides that subject to certain limitations, your surviving spouse and children may continue the group dental coverage at their own expense for up to 36 months. Federal law requires your Plan Administrator to send the surviving family members instructions as to how to apply for continued coverage if they are eligible.

Electing COBRA Coverage

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. Failure to provide timely and proper notice may result in the loss of the right to COBRA coverage.*

Qualified Beneficiaries must complete and return the COBRA election form in order to continue coverage. The notice will include instructions for completing and returning the form. 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 group plan would otherwise end. The required premium, including any retroactive premium, must be paid from the day coverage would have otherwise ended. The initial 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 whom such premium should be paid.

Second Qualifying Event — In the event your family experiences a second Qualifying Event while receiving an 18-month period of COBRA coverage (or the extended 29-month period), your covered spouse and dependents are eligible to extend the original COBRA coverage period to a maximum of 36 months if notice of the second event is properly given to the Plan Administrator. This extension may be available to the spouse and children receiving continuation coverage if: a) you die, b) you become entitled to Medicare, c) you get divorced or legally separated, or d) the dependent child is no longer eligible as a dependent, but only if the second event would have caused the spouse or child to lose coverage under the plan had the first Qualifying Event not occurred. In all of these cases, you or the dependent must notify the Plan Administrator, in writing, within 60 days of the second Qualifying Event. The notice must include sufficient information to enable the Plan Administrator to determine the group health plan to which the notice applies; the covered employee and qualified beneficiary(ies); the second Qualifying Event, and the date the Qualifying Event occurred. Failure to provide timely and proper notice may result in the loss of the right to extend COBRA coverage.

Termination Of COBRA Coverage

A Qualified Beneficiary's COBRA continuation coverage may be terminated at midnight on the earliest of:

- the day your employer ceases to provide any Group Dental Plan to any employee;
- the day the premium is due and unpaid;
- the day the individual first becomes covered under any other Group Dental 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 the individual again becomes covered as an employee or dependent under the policy;
- the day an insured person becomes entitled to benefits under Medicare (after COBRA election); or
- the day dental insurance has been continued for the maximum period of time allowed (18, 29 or 36 months).

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

Subrogation

Subrogation is the right to recover benefits paid for Covered Services provided as the result of Injury or Illness which was caused by another person or organization. When benefits are paid under the Master Group Contract, BCBSNE shall be subrogated to all of the Covered Person's right of recovery against any person or organization to the extent of the benefits paid. The Subscriber, the Covered Person or the person who has the right to recover for a Covered Person (usually a parent or spouse), agrees to make reimbursement to BCBSNE if payment is received from the person who caused the Illness or Injury or from that person's liability carrier.

This subrogation shall be a first priority lien on the full or partial proceeds of any settlement, judgement or other payment recovered by or on behalf of the Covered Person, whether or not there has been full compensation for all his or her losses or as provided by applicable state law. BCBSNE's rights shall not be defeated by allocating the proceeds in whole or in part to nonmedical damages.

Contractual Right To Reimbursement

If a Covered Person receives full or partial proceeds from any other source for Covered Services for an Illness or Injury, BCBSNE has a contractual right of reimbursement to the extent benefits were paid under the Contract for the same Illness or Injury. This contractual right to reimbursement shall be a first priority lien against any proceeds recovered by the Covered Person, whether or not the Covered Person has been fully compensated for all his or her losses, or as provided by applicable state law.

Such proceeds may include any settlement; judgment, payments made under group auto insurance; individual or group no fault auto insurance; another person's uninsured, underinsured or medical payment insurance; or proceeds otherwise paid by a third party. This contractual right to reimbursement is in addition to and separate from the subrogation right. Our rights shall not be defeated by allocating the proceeds in whole or in part, to nonmedical damages.

When proceeds are recovered under this contractual right to reimbursement for all or a part of the Claim, amounts previously credited to a Covered Person's Deductible or Coinsurance liability may be removed. Future Claims will be subject to the reinstated Deductible or Coinsurance.

No adult Subscriber may assign any rights to recover medical expenses from any third party to any minor or other dependent of the adult Subscriber or to any other person, without the express written consent of BCBSNE. The right to recover, whether by subrogation or reimbursement, shall apply to settlements or recoveries of deceased persons, incompetent or disabled Subscribers, or their incompetent or disabled Eligible Dependents.

The Subscriber agrees to fully cooperate and assist in any way necessary to recover such payments, including but not limited to notifying BCBSNE of a claim or lawsuit filed on his or her behalf or on behalf of any Eligible Dependent for an Injury or Illness. The Subscriber, Eligible Dependent or an authorized representative shall contact BCBSNE prior to settling any claim or lawsuit to obtain an updated itemization of its subrogation Claim or reimbursement amount due. Upon receiving any proceeds, the Subscriber, Eligible Dependent or an authorized representative must hold such proceeds in trust until such time as the proceeds can be transferred to the Plan. The party holding the funds that rightfully belong to the Plan shall not interrupt or prejudice the Plan's recovery of such payments.

If the Subscriber refuses or fails to comply with these provisions, coverage can be canceled, including that of any covered dependents. Costs incurred in enforcing these provisions shall also be recovered, including, but not limited to, attorneys' fees, litigation and court costs and other expenses.

Workers' Compensation

Benefits are not available for Services provided for Injuries or Illnesses arising out of and in the course of employment whether or not the Covered Person fails to assert or waives his or her right to Workers' Compensation or Employer Liability Law. The employer is required to furnish or pay for such Services or a settlement can be made, pursuant to Workers' Compensation laws. (See also the section of this book titled "Exclusions—What's Not Covered")

If a Covered Person enters into a lump-sum settlement which include compensation for past or future medical expenses for an Injury or Illness, payment will not be made under the group plan for Services related to that Injury or Illness.

Benefits are not payable for services determined to be not compensable due to noncompliance with terms, rules and conditions under Workers' Compensation laws, or in a Certified or otherwise Licensed Workers' Compensation Managed Care Plan. In addition, benefits are not payable for Services that are related to the work Injury or Illness, but are determined to be not necessary or reasonable by the employer or Workers' Compensation carrier.

In certain instances, benefits for such Services are paid in error under the group plan. If payment is received by the Covered Person for such Services, reimbursement must be made. This reimbursement may be refunded from any recovery made from the employer, or the employer's Workers' Compensation carrier, as permitted by law. Reimbursement must be made directly by the Subscriber when benefits are paid in error due to his or her failure to comply with the terms, rules and conditions of Workers' compensation laws or a Certified or Licensed Workers' Compensation Managed Care Plan.

DEFINITIONS

Section 11

Accident: An unexpected occurrence that results in injury, loss or damage such as a fall or auto accident. Fractures of teeth due to eating, biting or chewing are not considered Accidents.

Allowable Charge: An amount BCBSNE uses to calculate payment of Covered Services. This amount will be based on either the Contracted Amount for In-network Providers or the Out-of-network Allowance for Out-of-network Providers.

Annual Enrollment Month: The month during which membership additions and deletions are made. This month usually corresponds to the rating anniversary and must be mutually agreed upon by the Group Applicant and BCBSNE.

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 according to the terms of the Contract, Nebraska law and the direction of BCBSNE.

Certificate of Coverage: A document which summarizes information found in the Master Group Contract.

Certification (Certified): Successful voluntary compliance with certain prerequisite qualifications specified by regulatory entities.

Coinsurance: The percentage amount the Covered Person must pay for Covered Services, based on the lesser of the Allowable Charge or the billed charge.

Consultation: Dental services for a patient in need of specialized care requested by the attending Dentist who does not have that knowledge.

Contract: The agreement between BCBSNE and the Group Applicant which includes the Contract and any endorsements; the Master Group Application any subgroup application, addenda, the individual enrollment information of Subscribers and any financial agreements.

Contracted Amount: The payment agreed to by BCBSNE or an On-site Plan and contracting Providers for Covered Services received by a Covered Person.

Cosmetic: Any services provided to improve the patient's physical appearance, from which no significant improvement in physiologic function can be expected, regardless of emotional or psychological factors.

Covered Person: Any person entitled to benefits for Covered Services pursuant to the Contract administered by BCBSNE.

Covered Services: Dental procedures, supplies, drugs, or other dental care services, for which benefits are payable, while the Contract is in effect.

Deductible: An amount of Allowable Charges which must be met for the Covered Person each calendar year for Covered Services before benefits are payable by the Contract.

Dentist: Any person who is appropriately Licensed and qualified to practice dentistry under the law of the jurisdiction in which the dental procedure is performed and is operating within the scope of his/her license.

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. Children to age 26.

   "Children" means:
   - the Subscriber's biological and adopted sons and daughters,
   - a grandchild who lives with the Subscriber in a regular child-parent relationship where the grandchild receives no support or maintenance from the parent and where the Subscriber is a court-appointed guardian of the grandchild,
   - a stepchild (i.e. the son or daughter of the Subscriber's current spouse), or
   - a child, other than a grandchild or stepchild, for whom the Subscriber is a court-appointed guardian, but does not include a foster child.
3. Reaching age 26 will not end the covered child's coverage under the 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 26 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 BCBSNE. Any extended coverage under this paragraph will be subject to all other provisions of the Contract.

General Anesthesia: A controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including loss of ability to independently maintain airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non pharmacologic method or combination thereof.

Gingivectomy: The excision or removal of gingival tissue.

Group Applicant: The employer or association making application for dental coverage under the Contract.

Hospital: An institution or facility duly Licensed by the State of Nebraska or the state in which it is located, which provides medical, surgical, diagnostic and treatment Services with 24-hour per day nursing Services, to two or more nonrelated persons with an Illness, Injury or pregnancy, under the supervision of a staff of Physicians Licensed to practice medicine and surgery.

Illness: A condition which deviates from or disrupts normal bodily functions or body tissues in an abnormal way, and is manifested by a characteristic set of signs or symptoms.

Injury: Physical harm or damage inflicted to the body from an external force.

In-network Provider: A health care provider (Physician, Dentist, or other health care provider) who has contracted with BCBSNE to provide services as a part of the Preferred Provider network in Nebraska.

Investigative: A technology, a drug, biological product, device, diagnostic, treatment or procedure is Investigative if it has not been Scientifically Validated. BCBSNE will determine whether a technology is Investigative.

Late Enrollee: An individual who does not enroll for coverage during the first period in which he or she is eligible, or during a special enrollment period.

Licensure (Licensed): Permission to engage in a health profession that would otherwise be unlawful in the state where services are performed, and which is granted to individuals who meet prerequisite qualifications. Licensure protects a given scope of practice and the title.

Master Group Application: A form provided by BCBSNE, executed by the Group Applicant, and accepted by BCBSNE which becomes a part of the Contract.

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

Medically Necessary or Medical Necessity: Health care services ordered by a treating Physician exercising prudent clinical judgment, provided to a Covered Person for the purposes of prevention, evaluation, diagnosis or treatment of that Covered Person's Illness, Injury or pregnancy, that are:

1. Consistent with the prevailing professionally recognized standards of medical practice; and, known to be effective in improving health care outcomes for the condition for which it is recommended or prescribed. Effectiveness will be determined by validation based upon scientific evidence, professional standards and consideration of expert opinion, and
2. Clinically appropriate in terms of type, frequency, extent, site and duration for the prevention, diagnosis or treatment of the Covered Person's Illness, Injury or pregnancy. The most appropriate setting and the most appropriate level of service is that setting and that level of service, that is the most cost effective considering the potential benefits and harms to the patient. When this test is applied to the care of an inpatient, the Covered Person's medical symptoms and conditions must require that treatment cannot be safely provided in a less intensive medical setting; and
3. Not more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results as to the prevention, diagnosis or treatment of the patient's Illness, Injury or pregnancy, without adversely affecting the Covered Person's medical condition; and

4. Not provided primarily for the convenience of the following:
   a. The Covered Person;
   b. The Physician;
   c. The Covered Person's family;
   d. Any other person or health care provider; and
5. Not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnoses or treatment procedures.

BCBSNE will determine whether services are Medically Necessary. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a treating Physician.

Membership Unit: The category of person to be provided benefits, pursuant to the Subscriber's enrollment. The Subscriber may select one of the following types of Membership Units:

1. Single Membership: This option provides benefits for Covered Services provided to the Subscriber only.
2. Subscriber-Spouse Membership: This option provides benefits for Covered Services provided to the Subscriber and his or her spouse.
3. Single Parent Membership: This option provides benefits for Covered Services provided to the Subscriber and his or her Eligible Dependent children, but not to a spouse.
4. Family Membership: This option provides benefits for Covered Services provided to the Subscriber and his or her Eligible Dependents.

Other Membership Units may be chosen by the Group Applicant and will be defined in the Master Group Application. If other Membership Units are chosen, a Subscriber may select from those Membership Units as defined by the Group Applicant.

Noncovered Services: Services that are not payable under the Contract.

Occlusion: Any contact between biting or chewing surfaces of maxillary (upper) and mandibular (lower) teeth.

On-site Plan: A Blue Cross and/or a Blue Shield Plan in another Blue Cross and Blue Shield Association Service Area, which administers Claims through the BlueCard Program for Nebraska Covered Persons residing or traveling in that Service Area.

Orthognathic Surgery: Surgery performed to correct facial imbalances caused by abnormalities of the jaw bones.

Osteotomy: Surgical cutting of bone.

Out-of-network Allowance: An amount BCBSNE uses to calculate payment for Covered Services to an Out-of-network Provider. This amount will be based on the Contracted Amount for Nebraska Providers or an amount determined by the On-site Plan for out-of-area Providers.

Palliative: Action that relieves pain but is not curative.

Periodontal: Pertaining to the supporting and surrounding tissues of the teeth.

Physician: Any person holding an unrestricted license who is duly authorized to practice medicine and surgery, and to prescribe drugs.

Preferred Provider: A health care provider (Hospital, Dentist, Physician or other health care provider) who has contracted to provide Services as part of the network in Nebraska, or if in another state, who is a Preferred Provider with the BlueCard Program PPO network.

Preferred Provider Organization: Panel of Dentists, Physicians and other health care providers who belong to a network of Preferred Providers, which agrees to more effectively manage health care costs.

Pulpotomy: Surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing; pulp amputation.

Qualified Beneficiary: Under COBRA, an individual who must in certain circumstances, be offered the opportunity to elect COBRA coverage under a group health plan. The term generally includes a covered employee's spouse or dependent children who were covered under the group health plan on the day before a Qualifying Event, as well as a covered employee who was covered under the group health plan on the day before a Qualifying Event that is a termination of employment or a reduction in hours. The term also includes a child born to or adopted by a covered employee during a period of COBRA coverage.

Qualifying Event: The circumstances that entitle persons to elect COBRA coverage.

Root Canal: The portion of the pulp cavity inside the root of a tooth; the chamber within the root of the tooth that contains the pulp.

Schedule of Benefits: A summarized personal document which provides information about Deductibles, percentage payable, special benefits, maximums and limitations of coverage. It also indicates the type of Membership Unit selected and whether or not waiting periods are in effect. This term also includes the Schedule of Benefits Summary.

Scientifically Validated: A technology, a drug, biological product, device, diagnostic, treatment or procedure is Scientifically Validated if it meets all of the factors set forth below:

1. Technologies, drugs, biological products, devices and diagnostics must have final approval from the appropriate government regulatory bodies. A drug or biological product must have final approval from the Food and Drug Administration (FDA). A device must have final approval from FDA for those specific indications and methods of use that is being evaluated. FDA or other governmental approval is only one of the factors necessary to determine Scientific Validity.
2. The Scientific Evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

   The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, Injury, Illness or condition. In addition there should be evidence based on established medical facts that such measurement or alteration affects the health outcomes.

   Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Our evidence includes, but is not limited to: Blue Cross and Blue Shield Association Technology Evaluation Center technology evaluations; Hayes Directory of New Medical Technologies' Status; Centers for Medicare and Medicaid Services (CMS) Technology Assessments and United States Food and Drug Administration (FDA) approvals.
3. The technology must improve the net health outcome.
4. The technology must improve the net health outcome as much as or more than established alternatives.
5. The improvement must be attainable outside the investigational settings.

BCBSNE will determine whether a technology is Scientifically Validated.

Space Maintainer: A passive appliance, usually cemented in place, that holds teeth in position until the permanent teeth erupt.

Subscriber: An individual who enrolls for dental coverage and is named on an identification card issued pursuant to the Contract, and who is:

1. An employee hired by an employer who makes application for dental coverage for its employees,
2. A member of an association that makes application for dental coverage for its members, or
3. A retiree qualified to receive benefits as defined in the Master Group Application.

Temporomandibular Joint (TMJ): The connecting joint between the base of the skull (temporal bone) and the lower jaw (mandible).

BlueCross BlueShield of Nebraska

An Independent Licensee of the Blue Cross and Blue Shield Association.

AMENDMENT

THIS IS AN AMENDMENT TO YOUR CERTIFICATE OF COVERAGE. PLEASE READ IT CAREFULLY. THIS AMENDMENT BECOMES A PART OF YOUR CERTIFICATE OF COVERAGE AND SHOULD BE ATTACHED TO IT.

Steven S. Martin, President
and Chief Executive Officer

ELIGIBILITY

Who's Eligible

An employee must meet his or her employer's criteria for the minimun scheduled hours per week on a regular calendar year basis in order to be eligible for coverage. Coverage will be effective the first of the month following completion of the applicable probationary period, provided that employee enrolls for coverage within 31 days.

If an otherwise eligible employee is not actively at work on the effective date of coverage for other than personal health reasons, his or her coverage will not be effective until the first of the month following his/her return to work, subject to receipt of an enrollment form within 31 days of the employee's return to work date.

Initial Enrollment

Subscribers and dependents must enroll within 31 days of their initial eligibility or late enrollment provisions may apply.

Dental Enrollment

Employees and dependents whose dental enrollment forms are not received by BCBSNE within 31 days of their eligibility, shall not be eligible to apply for dental coverage until the next Annual Enrollment Month which follows the employee's eligibility date, unless BCBSNE approves a special enrollment period. Dental coverage for the first year following the Annual Enrollment Month will be limited to Coverage A only and premiums will not be reduced.

Special Enrollment

A period of 31 days is allowed for:

- enrollment of eligible persons due to marriage, birth, adoption or placement for adoption;
- enrollment of eligible persons not previously covered under this plan due to having had other coverage at the time it was previously offered, and who have lost that other coverage due to:
  - exhaustion of COBRA continuation coverage; or
  - a loss of eligibility, including loss due to death, divorce, legal separation, termination of employment or reduction in hours, or due to the plan no longer offering benefits to the class of individuals that includes the person (when the other coverage was not COBRA); or
  - moving out of the service area of an HMO or other arrangement that only provides benefits to individuals who reside, live or work in the service area; or
  - the employer ceasing to make contribution for the other coverage (when the other coverage was not COBRA).

A special enrollment period of 60 days is allowed for:

- Enrollment of eligible persons who were covered under Medicaid or State Child Health Insurance Program (SCHIP), which has been terminated due to loss of eligibility.
- Enrollment of eligible persons who have become eligible for premium assistance for this group health plan coverage under Medicaid or SCHIP.

The Subscriber must enroll (or already be enrolled) in order to enroll his or her dependents in this plan. In the case of a marriage, birth or adoption, a Subscriber who is eligible, but who has not previously enrolled, may enroll at this time with or without the newly Eligible Dependent. Likewise an otherwise Eligible Dependent who has not previously enrolled, may enroll as a Special Enrollee with or without a new dependent child.

Late Enrollment

A "late enrollee" is defined as a Subscriber or dependent who does not timely enroll, or does not enroll for coverage within the first period in which he or she is eligible to enroll. Late enrollment is only allowed during the group's open enrollment period. A person who enrolls for coverage during a "special enrollment period" is not considered a "late enrollee".

Open Enrollment

Eligible persons who do not enroll for coverage during the initial enrollment period or special enrollment period ("late enrollee"), may enroll during the open enrollment period. For additional information on the open enrollment period, please contact your Human Resource Department.

Adding A Dependent

Dependents cannot enroll unless you, the eligible employee, are covered under the Plan. In order to add a dependent, he or she must meet the definition of an Eligible Dependent.

Effective Date of Coverage

Provided that an appropriate membership option is in place and, if applicable, any additional premium is paid, the effective date of coverage will be as follows:

Marriage: The first day of the month following receipt of the enrollment form.

Newborn Children: Coverage will be provided for 31 days from the date of birth for the child of a Subscriber regardless of the membership option. In order to continue coverage, the newborn must be enrolled as a special enrollee within the 31-day period.

Newborn Children: Coverage will be provided from the date of birth for a child who meets the definition of an Eligible Dependent provided that the group is notified of the birth of the child and any enrollment procedures required by the group are met.

For additional information on adding newborn children, please contact your Human Resource Department.

Adopted Children: Coverage will be provided for 31 days from the earlier of the date the child is placed for adoption or the date a court order grants custody to the adoptive parents regardless of the membership option. (In order to avoid claim delays, you must notify BCBSNE of the adoption within 31 days of the placement.) In order to continue coverage, the adopted child(ren) must be enrolled as a special enrollee within the 31-day period.

NOTE: When adding a dependent, you must be enrolled under a membership option that provides coverage for your dependents. There are two membership options available to you, Single and Family. For an explanation of the available membership options, please see the section of this book titled "Definitions".

WHEN COVERAGE ENDS

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

- The date the entire Contract is terminated.
- The date your active employment is terminated.
- The date you cease to be eligible under the health plan; or a dependent ceases to be an Eligible Dependent.
- The date you voluntarily elect to terminate coverage for you or a dependent (subject to the pre-tax premium rules.)
- The last date for which premium is paid.
- If on leave under the Family Medical Leave Act (FMLA), the earlier of:
  - the date you fail to pay premiums,
  - the date you fail to return to work at the end of the leave,
  - the date you notify your employer that you do not intent to return from leave.
- Another date as specified by your employer.

NOTE: If an employee voluntarily cancels his/her dental coverage, the employee and his/her eligible dependents may not re-enroll for two years from the first month following the date of cancelation.

Trade Adjustment Assistance (TAA) Reform Act Of 2002

The Trade Adjustment Assistance (TAA) Reform Act provides benefits for Individuals eligible for trade adjustment assistance because international trade has adversely affected their employment. The Act provides that a TAA eligible individual who did not elect continuation coverage during the initial COBRA election period is entitled to a second 60-day election period. This election must take place no later than six month after the date of the TAA related loss of coverage. It also includes a federal tax credit for a percentage of premiums paid for qualified private health insurance coverage, including COBRA coverage.

Additional information regarding requirements and benefits under the TAA Reform Act may be obtained from the U.S. Department of Labor or the Nebraska Workforce Development Department of Labor.

Uniformed Service Employment And Reemployment Rights (Military Leave)

The Uniformed Services employment and Reemployment Rights Act of 1994 (USERRA) requires that continued coverage under an employer group plan be offered to an employee and covered dependents if coverage would otherwise be lost due to military leave.

Continuation of Group Health Coverage

If coverage under your employer group plan ends because of service in the uniformed services, you may elect to continue coverage yourself and your covered dependents, until the earlier of:

- 24 consecutive months from the date active duty began, or
- the day after the date on which you fail to apply for, or return to employment, in accordance with USERRA.

You are responsible for payment of the required premium to continue coverage. If the leave for military service is less than 31 days, your required premium is the standard employee share of the applicable premium . For a leave in excess of 30 days the required premium shall be no more than 102% of the total premium applicable for your membership option. Your employer will inform you of the amount and procedure for payment of premiums.

A Covered Person's continued coverage under these USERRA provisions will end at midnight on the earliest of:

- the day the employer ceases to provide any group plan for its employee,
- the day the premium is due and unpaid,
- the day a Covered Person again becomes covered under the plan,
- the day coverage has been continued for the period of time stated in the previous paragraph above.

Reemployment

Following service in the uniformed services, an employee may be eligible to apply for reemployment with the employer in accordance with USERRA. Such reemployment includes the right to reenroll for group coverage provided by the employer with no new waiting periods imposed.

Please contact your Human Resources Department for further information with regard to your rights under USERRA.

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