BlueDental

PREFERRED PROVIDER ORGANIZATION
INDIVIDUAL DENTAL CONTRACT

BlueDental is a preferred provider organization dental benefits plan offered by Blue Cross and Blue Shield of Nebraska (BCBSNE), a mutual insurance company, licensed by the State of Nebraska.

This Contract is underwritten and administered by Blue Cross and Blue Shield of Nebraska. The Contract provides In-network benefits for specific dental Services provided to Covered Persons by Preferred Physicians, Dentists, Hospitals, and other health care providers. These providers have agreed to furnish Services to Covered Persons in a manner reasonably expected to effectively manage health care costs. This Contract also provides Out-of-network benefits for dental Services performed by Out-of-network Providers.

Blue Cross and Blue Shield of Nebraska agrees to make payment for the services described, defined and limited herein, during the term of this Contract. This Contract will start at 12:01 a.m., at your principal place of residence, on the effective date stated in your Application, and in consideration of the Application and payment of premiums.

The entire Contract of insurance consists of the Application, your Schedule of Benefits, this document and any attachments or endorsements hereto. It will be renewed each month when you pay your premium. We may cancel this Contract if you fail to pay your premium or for the other reasons stated in Part III.C.

Only an Officer of Blue Cross and Blue Shield of Nebraska can approve a change to this Contract and that change must be in writing. Any change will affect all Covered Persons, and no agent may change the Contract in any way.

This Contract is made in and governed by the laws of the State of Nebraska.

Throughout this Contract, Blue Cross and Blue Shield of Nebraska will be referred to by the personal pronouns "we," "our," and "us." The person making application will be referred to as the Subscriber or by the personal pronouns "you" or "your." The defined terms are capitalized in this Contract.

BLUE CROSS AND BLUE SHIELD OF NEBRASKA

Jeff Russell, President and
Chief Executive Officer

NOTICE

If, after examination of this Contract, you are not satisfied for any reason, it may be returned to Blue Cross and Blue Shield of Nebraska or its agent within ten days of its delivery to you. If returned, any premium paid will be refunded, the Contract will be void from the beginning, and all parties will be in the same position as if no Contract had been issued.

TABLE OF CONTENTS

Part I. ELIGIBILITY, EFFECTIVE DATE OF COVERAGE, CHANGE OF COVERAGE, WAITING PERIODS, EVIDENCE OF COVERAGE

A. ELIGIBILITY: To be eligible for this Contract, you must meet the following requirements:

1. You must be, and remain, a resident of the State of Nebraska. If you move from the State of Nebraska, we may cancel your coverage. If we cancel your coverage under these circumstances, we will provide you with 31 days written notice.

2. You must complete an Application and elect a Membership Unit. If you do not complete your Application truthfully, and we discover that fact, we may rescind or cancel coverage. If we rescind coverage, you or your dependents will not be eligible for any of the benefits provided by this Contract and we will refund the premiums you have paid, less any benefits which have been paid.

3. You must pay the premium by the due date.

4. Any person who is eligible for Blue Cross and Blue Shield of Nebraska group dental coverage will not be eligible for coverage under this Contract.

5. All dependents for whom coverage is requested must meet the definition of an Eligible Dependent.

6. Child Support Order: If you are subject to a court order to provide coverage for your child or children as a result of a divorce, legal separation or paternity determination, a copy of the Child Support Order or administrative order must be submitted to us. This order may create a right to enroll the child as well as create a right for an alternate recipient to receive benefit plan information and to submit claims and receive benefits for services.

B. EFFECTIVE DATE OF COVERAGE: Upon acceptance by us of your Application and applicable premiums, subject to the required waiting periods, coverage shall commence as follows:

1. Coverage for you and any Eligible Dependents shall begin the first day of the month following our approval of your Application. You may request an earlier effective date provided it is not prior to the date of your Application. Your effective date will be shown on your Schedule of Benefits.

2. If you change from a Single Membership to coverage that includes dependents, coverage of your Eligible Dependents shall begin on the next monthly due date of the Contract following our approval of the Request For Change Form. You may request an earlier effective date as long as it corresponds to the first day of the month following the dependents' initial eligibility date.

A newly-married Subscriber may request to backdate the effective date of a Family Membership to the first of the month in which the marriage occurs if the Request For Change Form and additional premium are received by us within 31 days of the marriage. Coverage for your spouse and any new Eligible Dependents shall then begin on the date of marriage, subject to any applicable waiting periods.

3. Coverage shall begin at birth for children of a Subscriber born after the effective date of the Subscriber’s coverage. This includes coverage for Covered Services for Injury or Illness (including the necessary care and treatment of medically-diagnosed Congenital Abnormalities). This coverage will be provided for 31 days from the date of birth for the child of a Subscriber with a Single Membership then in effect. To continue coverage, a request

must be made to change the Membership to Family or Single Parent Membership within the 31-day period, and any applicable additional premium must be paid.

Coverage will also begin at birth for the child of an Eligible Dependent of a Subscriber with an existing Family or Single Parent Membership, provided such child meets the definition of an Eligible Dependent.

Coverage for a newly adopted child of the Subscriber shall begin the earlier of the date of placement for adoption or the date of entry of an order granting custody to the adoptive parents for purposes of adoption. Coverage shall be the same as for other Eligible Dependents. If a change to the Membership Unit is necessary a Request For Change Form must be submitted and any additional premium must be paid within 31 days of the adoption, in order to continue coverage beyond the initial 31-day period.

C. CHANGE OF COVERAGE:

1. All changes to your Membership Unit must be made in writing. Dependents must meet the definition of Eligible Dependent to be enrolled for coverage.

2. If you request a change to your coverage, we will require that you complete a Request For Change Form.

3. **Continuing Coverage:** When your coverage is discontinued while having a Subscriber-Spouse, Single Parent or Family Membership, we will offer to continue a Single, Single Parent, or Family Membership to your covered dependents. We must be notified of such event and payment must be made within 31 days in order for coverage to continue.

If a person ceases to be an Eligible Dependent, we will provide a comparable Single Membership for that person, provided eligibility requirements are met. For such coverage to become effective, however, that person must make application and pay the initial premium within 31 days of the date dependent eligibility ceases.

The coverage offered under this paragraph will be the most recent version of this BlueDental Contract. It will be subject to any unexpired waiting periods required by the preceding coverage. If we do not receive application for coverage or payment of the premium within the time limits fixed above, all rights and privileges to continue coverage will lapse.

4. Re-enrollment: If this coverage is voluntarily cancelled, the Subscriber and his or her Eligible Dependents may re-enroll for coverage subject to new waiting periods, regardless as to how long the coverage had been in effect, or the length of time since termination.

D. WAITING PERIODS: Benefits for Coverage B and Coverage C services (if applicable to your plan) are subject to a waiting period, unless otherwise waived by us. The waiting period is stated on the Application and/or Schedule of Benefits.

E. EVIDENCE OF COVERAGE: When your coverage becomes effective, we will provide you with this Contract, a Schedule of Benefits, and an Identification Card.

The Identification Card identifies you as a Subscriber who has coverage under this Contract. The Covered Person must present this Card to the provider when receiving Services.

PART II. CHARGES FOR COVERAGE, CONTRACT CHANGES

A. The charges for this coverage are called premiums. Premiums are payable in advance at our offices in Omaha, Nebraska. This Contract will be renewed each month when you pay your premium, unless canceled pursuant to the Cancellation provision.

B. Your premium may be based on factors such as gender, age and geographic area, as well as the Membership Unit and plan option selected, as of the annual renewal date each year. Your premium is determined from the Table of Rates which is incorporated and made part of the Contract.

C. We reserve the right, on any premium due date, to change the amount of the monthly premium. Any change to the premium shall apply equally to all premiums based on the same rating factors. No such changes, if initiated by us, shall be effective less than 31 days after written notice is mailed to you at the most recent address appearing in our records.

D. We will refund any premium paid if you provide us with proof in writing that such premium was collected as the result of our error. If we determine the reason for a valid refund request was not the result of our error, any refund of premium is limited to the 12-month period before our receipt of your written request.

PART III. GRACE PERIOD; REINSTATEMENT; CANCELLATION; TERMINATION

A. GRACE PERIOD: A grace period of ten days will be granted for the payment of monthly premiums, or 31 days for quarterly premiums. Your Contract will continue in force during this grace period. This provision is subject to our right to cancel in accordance with the Cancellation provision.

B. REINSTATEMENT: If any renewal premium is not paid within the time granted for payment, our later acceptance of the premium will reinstate the Contract. If we require an application for reinstatement and we issue a conditional receipt for the premium paid, the coverage will be reinstated upon our approval of such application. If we have not approved the application or previously notified you in writing of disapproval of such application, coverage will be reinstated on the 45th day following the date of such conditional receipt.

The reinstated coverage will include only loss resulting from an Injury sustained after the date of reinstatement and loss due to an Illness that begins more than ten days after such date. In all other respects, the parties will have the same rights as they had immediately before the due date of the defaulted premium, subject to any provisions applicable to reinstatement. Any premium accepted in connection with reinstatement will be applied to a period for which a premium has not been previously paid, but not to any period more than 60 days prior to reinstatement.

C. CANCELLATION: We may cancel this Contract for any of the following reasons:

1. If you fail to pay premiums.

2. If you, or someone acting on your behalf, or acting under your Membership, commits fraud or an act of misrepresentation involving the Application or Contract, or benefits payable under this Contract.

If a fraudulent misrepresentation is made on an application for coverage and that fact is discovered within two years of the application, coverage may be rescinded and the Subscriber or dependents will not be eligible for benefits. The amount of premiums paid for coverage will be reduced by any benefits that were paid and will be refunded to you. Neither the acceptance of premiums nor the processing of claims will constitute a waiver of our rights under this paragraph.

3. If you fail to comply with the requirements of the Part titled, Subrogation.

4. If you no longer meet eligibility or residency requirements.

5. If we cancel all contracts of the same contract form number and date.

We will provide written notice of cancellation to you by first class mail at your last known address, as shown by our records. Notice will be given at least 31 days prior to the effective date of cancellation, except in those cases where cancellation is due to your failure to pay premiums, or in cases of fraud or misrepresentation. Cancellation for failure to pay premiums shall be effective at midnight on the last day for which the premium has been paid, subject to the Grace Period provision. In cases of fraud or misrepresentation, coverage shall be canceled upon the date notice is given, or any later designated date, or it may be rescinded. If this Contract is canceled, cancellation will not affect any valid claim for services provided prior to the effective date of cancellation.

D. TERMINATION: You may terminate this Contract by notifying us in writing. If you terminate this Contract, we will not send a notice of cancellation. Following our receipt of your notification, the Contract will terminate on the earlier of the end of the month in which the notice is received or the end of the period for which premiums have been paid, unless an earlier date is specified by you in your notice. Coverage may not, however, be terminated in this manner on a date earlier than our receipt of notification. In the event of termination by you, we will return the prorated unearned premium to you. Termination will not affect any claim for services provided prior to the effective date of termination.

Unless requested by you as stated above, or as otherwise stated in this Contract, the effective date of cancellation or termination will be at 12:01 a.m. on the last day of the month for which premiums have been paid.

E. UNPAID PREMIUM: Upon the payment of a claim under this plan, any premium due and unpaid or covered by any note or written order may be deducted therefrom.

PART IV. BENEFITS OVERVIEW

A. PAYMENT FOR SERVICES: This Contract provides benefits for Covered Services provided to Covered Persons, subject to any exclusions and limitations outlined in this Contract. The benefit payment is determined by the following guidelines:

1. **In-network Providers:** We have contracted with a panel of Dentists and Physicians to furnish services to Covered Persons in a manner reasonably expected to effectively manage costs. These providers are called In-network Providers. An In-network Provider includes a provider who is contracting with an On-site Plan as part of the Preferred Provider network. These In-network Providers have agreed to be reimbursed a Contracted Amount for Covered Services. An In-network Provider agrees to accept our payment, plus the Covered Person's payment of any Deductible and Coinsurance as payment in full for Covered Services. The Covered Person is responsible for charges for Noncovered Services. Coinsurance is based on the lesser of the Allowable Charge or the billed charge for a Covered Service after the

Deductible is applied. Payment will be made to the In-network Provider. When an In-network Provider is used, the Covered Person is not responsible for any amount in excess of the Contracted Amount.

2. **Out-of-network Providers:** Benefits for Covered Services will be paid based on the lower of the Dentist's billed charge or the Out-of-network Allowance. This Allowable Charge shall be reduced by the Out-of-network Deductible and Coinsurance. The Covered Person is responsible for the payment of the Deductible, Coinsurance and any amount charged by the Dentist which is in excess of the Out-of-network Allowance for the Covered Service. The Covered Person is also responsible for payment for any Noncovered Services.

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. These providers have agreed to accept our payment, plus the Covered Person's payment of the Out-of-network Deductible and Coinsurance as payment in full for Covered Services. The Covered Person is also responsible for payment for any Noncovered Services.

3. **Right to Change Dental Providers or Benefit Payment Procedures:** Agreements with health care providers (including, but not limited to, dental providers) may be changed or terminated and benefit payment procedures to Preferred Providers may be altered. Benefit payments may be calculated on a charge basis, an Allowable Charge or similar charge, global fee basis, through a Preferred Provider Organization, or in any other manner agreed upon between BCBSNE or the On-site Plan and the provider. However, any payment method agreed upon, will not affect the method of calculating the Deductible and Coinsurance.

4. **Direct Payment:** All payments for Covered Services provided by In-network Dentists and other In-network Providers, or any provider who is participating with us pursuant to any other reimbursement program, will be made directly to such providers, unless otherwise provided under state or federal law, including qualified medical child support orders. In all other cases, payments, at our option, will be made to the Subscriber, to his or her estate, or to the provider. No assignment of any amount payable according to this Contract for services which are provided within the State of Nebraska, whether made before or after services are provided, shall be recognized or accepted as binding upon BCBSNE, unless otherwise required by state or federal law. Assignments to out of state providers will be recognized by BCBSNE.

5. **Payment:** All benefits payable under this Contract will be paid as soon as possible after the claim has been filed.

Payment by us for a specific service shall not make us liable for further payment for the same service or condition.

We may recover payments made in error as provided by law. Duplicate or erroneous payments not recovered will be considered as benefits paid under the Contract.

6. **Not Medically Necessary Services:** When an In-network Provider is used, the Covered Person is not responsible for payment for Services determined by us to be not Medically Necessary. When Services are received in another state, responsibility for not Medically Necessary Services will be governed by the agreement between the On-site plan in that state and its BlueCard PPO Providers. When Out-of-network Providers are used, Covered Persons will be responsible for payment for Services determined by us to be not Medically Necessary.

EXCEPTION: For any specific Service determined to be not Medically Necessary, including ongoing preventive or maintenance therapy, an In-network Provider may collect from the Covered Person if prior to the Service being provided, the provider has advised the Covered Person in writing of his or her responsibility for payment, and the Covered Person has agreed in writing to be responsible. If written agreement cannot be obtained, prior verbal notification may be given by the provider and must be documented in the patient's medical record at the time such notification is given.

7. **Expansion of Benefits:** The scope of benefits in an individual case may be expanded solely on a concurrent/prospective basis as determined by BCBSNE, to include payment for specific services which would not ordinarily be included as Covered Services. It must appear that use of such services will equal or reduce costs, improve the quality of medical care or be medically more appropriate than an alternate Covered Service. BCBSNE will advise the Covered Person and the provider in writing when, and to what extent, payment for such services will be made. Such expansion of the scope of benefits will not constitute an amendment to this Contract, nor provide a continuing right to receive such services.

8. **Request for Estimate of Allowable Charge for Out-of-network Provider Services:** The Covered Person may contact Blue Cross and Blue Shield of Nebraska for a good faith estimate of the dollar amount of the Allowable Charges for a service or procedure provided in Nebraska by an Out-of-network Provider. The request must include any service or procedure code number or diagnosis related group provided by the Out-of-network Provider and the provider's estimated charge.

B. DEDUCTIBLE: A Deductible may be applicable to one or more of the types of coverage described in this Contract. The Deductible must be met each calendar year by each Covered Person. The Deductible may be met when Allowable Charges for Covered Services incurred in that calendar year equal the Deductible stated in the Subscriber's Schedule of Benefits. The first calendar year begins on the effective date of coverage and ends on December 31 of that same year.

C. COINSURANCE: Coinsurance is the percentage of each Allowable Charge which the Covered Person must pay after payment of the applicable Deductible. The Coinsurance percentage is stated on your Schedule of Benefits.

D. WAIVER OF COINSURANCE OR DEDUCTIBLE: If a provider routinely waives (does not require the Covered Person to pay) the Coinsurance or Deductible for Covered Services, he or she is misstating the actual charge. We are not obligated to pay the full percentage of the provider's original charge, but instead, will pay benefits based on the lower fee actually charged.

E. TOTAL BENEFITS: The total benefits or calendar year benefits available under this Contract are stated in the Schedule of Benefits.

F. MEDICAL RECORDS: In consideration for the processing of claims, we will be entitled to receive without charge, from the Subscriber and all providers of Services, such facts, records, and reports about the examination or treatment of Covered Persons as may be needed to process claims or to determine the appropriateness of benefit payment.

G. INDEPENDENT CONTRACTORS: Blue Cross and Blue Shield of Nebraska does not engage in the practice of medicine, and all Contracting Providers provide Covered Services under the terms of this Contract as independent practitioners of the healing arts. Such providers are not employees or agents of Blue Cross and Blue Shield of Nebraska or the On-

site Plan, and we will not be liable for any act, error or neglect of any Hospital, Physician, Dentist or other provider or their agent, employee, successor or assignee.

PART V. CERTIFICATION

Certification (Preauthorization) is intended to determine if Services and supplies are appropriate under the terms of the Contract. A Dentist may also submit a Certification request to obtain a pre-treatment estimate of benefits. Certification does not guarantee payment, all other contractual provisions apply.

Written requests for Certification should be submitted to address on the back of the Identification Card.

PART VI. COVERAGE FOR DENTAL SERVICES

A. TYPES OF COVERAGE: The types of coverage, the Deductibles, Coinsurance, and the total benefits (overall and calendar year) are stated on the Covered Person's Schedule of Benefits.

1. Coverage A (preventive and diagnostic dentistry) shall provide benefits for:

   a. Two comprehensive and/or periodic oral examinations, including Periodontal, per calendar year.

   b. Two prophylaxis, including Periodontal, including cleaning, scaling and polishing of teeth per calendar year.

   c. One topical fluoride application per calendar year for Covered Persons through age 18.

   d. One fluoride varnish per calendar year through the age of 18.

   e. Dental x-rays:
      (ii) Occlusal not more than two series every two calendar years;
      (iii) Periapical not more than four single x-rays every calendar year;
      (iv) Not more than one full mouth or panorex series of x-rays covered one time per five calendar year period; and
      (v) One set of four supplemental bitewing x-rays in a calendar year.

2. Coverage B (maintenance and simple restorative dentistry) shall provide benefits for:

   a. General Anesthesia, 1) when Medically Necessary and administered in conjunction with oral or dental surgery, and 2) if the anesthetic agent produces a state of unconsciousness.

   b. Intravenous (IV) sedation, nitrous oxide, analgesia, non-intravenous conscious sedation or trigeminal division blocks/regional blocks are covered when performed in conjunction with complex surgical services.

   c. Restorations of silver amalgam and/or composite materials (if gold is used as a filling material, reimbursement will be made as for amalgam), limited to one per tooth surface every two calendar years.

d. Temporary crowning of teeth as a result of an Accident and provided within 72 hours of the Accident.

e. Resin-Based Composite Resin Crown, but not more than one tooth every two calendar years.

f. Pre-fabricated or stainless steel crowns, but not more than one time per five calendar year period through the age of 18.

g. Space Maintainers for extracted primary, posterior teeth covered one time per area through the age of 16.

g. Dry socket treatment.

h. Emergency Treatment.

i. Application of sealants to the permanent first or second molar teeth, not more than one time per lifetime through the age of 15.

j. Pulp Vitality tests.

k. Endodontic Services (treatment of diseases or injuries of pulp chambers, Root Canals and periapical tissue) consisting of:

1) Vital Pulpotomy covered one time per tooth per lifetime;

2) Root Canal therapy but not more than one time per tooth per lifetime;

3) Pulpal Therapy on primary teeth covered one time per tooth per lifetime.

4) Endodontic Retreatments covered one time per tooth per lifetime.

5) Bone graft with periradicular surgery

c. Oral surgery consisting of:

1) Simple and impacted extractions (not available for orthodontic extractions);

2) Alveoloplasty;

3) Surgical incision and drainage of dental abscess; and

4) Excision of hyperplastic tissue.

5) Complex surgical extractions

6) Vestibuloplasty

7) Surgical reduction of osseous tuberosity

3. Coverage C (Periodontal services and complex restorative dentistry) shall provide benefits for:

a. For the following Periodontal Services (treatment of diseases of gums and supporting tooth structure), only one service is covered per three calendar year period per single permanent tooth or multiple teeth in the same quadrant, unless otherwise specified below.

1) Gingivectomy;
2) Gingival curettage;
3) Osseous surgery, including flap entry and closure;
4) Osseous graft;
5) Scaling and root planing, one per quadrant every 2 calendar years;
6) Mucogingivoplastic surgery;
7) Treatment of acute infection and oral lesions;
8) Full mouth debridement, but not more than once per lifetime;
9) Gingival flap;
10) Apically positioned flap;
11) Bone Replacement graft;
12) Pedicle soft tissue graft;
13) Free soft tissue graft;
14) Combined connective tissue and double pedicle graft; and
15) Distal/proximal wedge – covered on natural teeth only.

b. Recement inlays and crowns on diseased or damaged teeth, but only for six months after initial placement.

c. Onlays and/or Permanent Crowns, one (1) time per five calendar year period per permanent tooth.

d. Inlays when used as abutments for fixed bridgework, covered one (1) time per two calendar year period per tooth surface. Benefits will be limited to those of an amalgam (silver filling). The Covered Person will be responsible for the difference in cost between what the policy allows for silver fillings, and what is changed for most costly fillings, plus the deductible and coinsurance.

e. Installation of permanent bridges are covered one time per five calendar year period: for ages 16 and older, and; if no more than 3 teeth are missing in the same arch; if none of the individual units of the bridge has been covered previously as a crown or a cast restoration in the last 5 years; if 5 years have elapsed since the last covered bridge, replacements will be covered only if the existing bridge cannot be repaired or adjusted.

f. Dentures--full and partial are covered one time per five calendar year period: for ages 16 and older, and; if 5 years have elapsed since the last covered removable

prosthetic appliance, replacements will be covered only if the existing appliance cannot be repaired or adjusted.

g. Repair of dentures, bridges, and cast restorations. Covered one time per six-month period.

h. Repair of crowns, but not more than one time per 12 month period.

i. One denture reline and rebase, not more than one time per two calendar year period.

j. Adjustments of dentures after at least six months from the date of installation, but not more than two times per one calendar year period.

k. Partial and Bridge adjustments. Covered two times per two calendar year period when the partial or bridge is a permanent appliance and after at least six months following the placement of the denture.

l. Implant Supported Fixed and Removable Prosthetic. Covered one time per five calendar year period. Implant and implant related services are not covered.

PART VII. EXCLUSIONS AND LIMITATIONS

A. EXCLUSIONS**:** Benefits are not provided by this Contract for the following:

1. Services that are not Covered Services under this Contract, or services to the extent they exceed the limitations stated in this Contract. If a Noncovered Service is provided to a Covered Person, the responsibility for payment rests with the Covered Person unless otherwise provided in this Contract. **Noncovered Services include, but are not limited to, any services, procedures or supplies for, or related to:**

a. Services for orthodontic dentistry including but not limited to, cephalometric x-rays, surgical exposure to aid eruption, extractions, casts and models, and the initial and subsequent installation of orthodontic appliances and orthodontic treatments. (Coverage D)

b. Services for treatment of the Temporomandibular (jaw) Joint, except as specifically provided for accidental Injury. This exclusion includes but is not limited to, TMJ x-rays, treatment for occlusal equilibration (grinding of teeth), the initial and subsequent installation of appliances and treatments, open and closed operative procedures. (Coverage E)

c. Dental services with respect to congenital malformations (including, but not limited to missing teeth) or primarily for Cosmetic or aesthetic purposes. Benefits shall be provided for reconstructive dental surgery when such dental procedures are (i) incidental to or following surgery resulting from injury, illness or other diseases of the involved part, or (ii) when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician. Such coverage is provided within the applicable plan limitations, maximums, deductibles and payment percentages.

d. 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.

e. Gold restorations, except as limited under Coverage C.

f. Full or partial replacement covered one time per five calendar year period for ages 16 and older, and if five years have elapsed since the last covered removable prosthetic appliance, replacements will be covered only if the existing appliance cannot be repaired or adjusted for:

1) A denture replacement made necessary by reason of the loss or theft of a denture.

2) A dental appliance or prosthesis that is replaced by reason of a loss or theft.

3) Crown, bridge, inlay and denture replacement made less than five calendar years after placement or replacement, and which were covered initially under this Contract.

g. Caries susceptibility tests, bacteriologic studies and histopathologic exams.

h. Magnetic resonance imaging and computed tomography (CT) scans.

i. Replacement of third molars with prostheses.

j. Education or training in, and supplies used for dietary or nutrition counseling, personal oral hygiene or dental plaque control.

k. Implants or any procedure associated with the preparation for, maintenance of or placement or removal of implants, except as otherwise indicated in this Contract. (Implants are defined as artificial material grafted or implanted into or onto bone.)

l. For any procedure begun after coverage under this Contract terminates or for any prosthetic dental appliance installed or delivered more than 30 days after coverage terminates.

m. 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, within six months of the completion of the service but not more than one time per two calendar year.

n. Duplication of x-rays.

o. Extraoral x-rays.

p. Injectable drugs or drugs dispensed in a provider's office.

q. Pulp Cap.

r. Root Resection/Root Amputation.

s. Hemisection.

t. Veneers.

u. Tooth Re-implantation.

v. IV sedation and Intravenous conscious sedation when services are performed with non-complex surgical dental care.

2. Services determined by us not to be payable after a request for Certification is considered.

3. Services which are determined by us to be not Medically Necessary. When an In-network Provider is used, the Covered Person is not responsible for payment for Services determined by us to be not Medically Necessary, unless otherwise agreed upon as allowed in Part IV.

4. Services and procedures and any supplies which are considered by us to be Investigative, or for any related services or complications.

5. Services, procedures or any supplies which are considered to be for Cosmetic purposes, or for any related services.

6. Services, procedures or any supplies which are considered by us to be obsolete, or for any related services. Procedures will be considered to be obsolete when such procedures have been superseded by more efficacious treatment procedures, and are generally no longer considered effective in clinical medicine or dentistry.

7. Charges made for filling out claim forms or furnishing any other records or information or special charges such as dispensing fees, administrative fees, technical support utilization review charges which are normally considered to be within the charge for a service; or charges for missed appointments.

8. Services provided to:

a. A dependent of a Covered Person who has Single Membership.

b. Any person who does not qualify as an Eligible Dependent.

c. Any Covered Person before his or her effective date of coverage, or after the effective date of cancellation or termination of this coverage.

d. Any Covered Person for which coverage is not available because of Contract waiting periods.

9. Interest, sales or other taxes or surcharges. This shall include taxes or surcharges levied by governmental bodies or subdivisions who do not have jurisdiction over this Contract.

10. Charges which exceed the calendar year or total benefits; charges which exceed the reimbursement amount or the Allowable Charge; or charges which exceed the actual charge for the service.

11. 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.

12. Services provided in or by: (a) a Veterans Administration Hospital where the care is for a condition related to military service; or (b) 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.

13. Services available at governmental expense. If payment for these services is required by federal or state law, unless otherwise provided under such law our obligation to provide benefits will be reduced by the amount of payments a Covered Person is eligible for under such program, whether or not the person has enrolled in the program. This provision is not applicable to Medicaid.

14. Services for which there is no legal obligation to pay, or for which no charge would be made if this coverage did not exist. Any charge above the charge that would have been made if no coverage existed, or any service which is normally furnished without charge will be treated as a service for which there is no legal obligation to pay.

15. Services arising out of or in the course of employment, whether or not the Covered Person fails to assert or waives his or her rights to workers' compensation or employers' liability law. This includes services determined to be work-related under workers' compensation laws, or under a workers' compensation managed care plan, but which are not payable because of noncompliance with such law or plan.

16. Charges for services provided by a person who is a member of the Covered Person's immediate family by blood, marriage or adoption.

17. 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.

18. Charges made separately for services, supplies or materials when such services, supplies and materials are considered by us to be included within the charge for a total service payable under this Contract, or a charge that is payable to another provider.

19. Charges made pursuant to an intentionally inflicted Injury, engaging in an illegal occupation or resulting from commission of or attempt to commit a felony.

20. 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.

21. Charges for services provided by a Hospital, ambulatory surgical facility or any other facility charge.

22. 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.

23. 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.

24. Core buildup.

25. Cast post and core in addition to crown.

26. Periodontal Splinting.

27. Apicoectomy or Periradicular Services.

28. Treatment of root canal obstruction – non-surgical or internal root repairs.

29. Localized delivery of antimicrobial agents, unscheduled dressing changes, and gingival irrigation.

30. Anatomical crown exposure, crown lengthening, or guided tissue regeneration.

31. Occlusal procedures, including occlusal guards and adjustments.

32. Any other oral surgery procedures that are not specifically listed as covered above.

33. Dental services, appliances, or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

34. Case presentations, consultations, teledentistry, and office visits.

35. Athletic mouth guards, enamel microabrasion and odontoplasty.

36. Bacteriologic tests.

37. Cytology sample collection.

38. Separate services billed when they are an inherent component of a dental service where the benefit is reimbursed at the Maximum Allowable Fee.

39. Interim or temporary removable or fixed prosthetic appliances (dentures, partials, or bridges).

40. Maxillofacial prosthetics.

41. Fixed pediatric partial dentures.

42. Additional, elective or enhanced prosthetic procedures including but not limited to, connector bar(s), stress breakers, and precision attachments.

43. Placement or removal of sedative filling, base or liner used under a restoration.

44. Adjunctive diagnostic tests.

45. Cone beam images, MRIs, Ultrasounds, or Sialoendoscopy.

46. Sinus augmentation.

47. Brush biopsy and the accession of a brush biopsy.

48. Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

B. LIMITATIONS**:**

1. If, in the construction of a denture or fixed bridgework to replace missing teeth, the Covered Person and the Dentist decide on personalized restoration or to employ special techniques as opposed to standard procedures, the benefits provided shall be limited to the standard procedures for prosthetic services as determined by BCBSNE.

2. If a Covered Person transfers from the care of one Dentist to another during a course of treatment, or if more than one Dentist provides services for one Covered Service, our liability shall not exceed what it would have been had only one Dentist provided the service.

3. The Covered Person is entitled to extended benefits for Covered Services up to 30 days after termination of this Contract for: a) 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 Contract; b) crowns, bridges, inlays or onlay restorations, but only if the tooth or teeth were fully prepared while the person was covered under this Contract and c) full or partial dentures, but only if the master impression was made while the person was covered under this Contract.

This extended coverage ceases on the earlier of: a) the end of the 30-day extension period; or b) the date the person becomes eligible for such services under other dental coverage.

4. If there are optional techniques of treatment with different charges, our liability shall not exceed the lower charge.

5. Benefits for exams are limited to one exam per day when an initial or a periodic oral exam is performed during the same visit.

6. The total benefits per Covered Person for the types of coverage set forth described in this Contract are indicated on the Schedule of Benefits.

PART VIII. CLAIM FILING AND APPEAL PROCEDURES

A. NOTICE OF CLAIM: A claim is a request for benefits under this Contract and is defined as either a "preservice" or "postservice" claim. A claim is considered to be a "preservice" claim when the terms of the plan **require** approval of the benefit in advance of obtaining medical care, and failure to do so will cause benefits to be denied or reduced. A postservice claim is any claim that is not a preservice claim. In most instances, a postservice claim is written proof that Services already have been received by the Covered Person. In order to receive benefits under this Contract, Blue Cross and Blue Shield of Nebraska must be notified when the Covered Person has received Services.

The postservice claim for benefits may be filed directly by the Covered Person (claimant), the Dentist, the Physician or other health care provider. **If the providers are contracting with Blue Cross and Blue Shield of Nebraska, the claim will be filed directly by them**.

The information required to process a postservice claim includes: the first and last name of the claimant, identification number including the alpha prefix, date of service, an itemized statement describing the service, the diagnosis, amount charged for the care and the provider's full name and credentials.

B. CLAIM FORMS: Upon receipt of a notice of claim, we will furnish to the claimant such forms as are usually furnished for filing proofs of loss. If such forms are not furnished within 15 days after we receive such notice, the claimant shall be deemed to have complied with the requirements of this plan as to proof of loss upon submitting, within the time fixed in the plan for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

C. **TIME LIMIT FOR FILING OR ADJUSTING A POST-SERVICE CLAIM**: A claim should be filed by a Provider or Covered Person as soon as possible after expenses are incurred. A proof of loss must be filed within 90 days. **If the claim is not filed by the Provider or Covered Person within 15 months (except in the absence of legal capacity) of the date of Service, benefits will not be paid.** Claims, including revisions and adjustments, that are not filed by a Nebraska Contracting Provider prior to the claim filing limit, will become the Nebraska Contracting Provider's liability.

Claims should be sent to:

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

D. CLAIM DETERMINATIONS:

1. **Preservice claims** that are not "urgent" (see below) will be processed within 15 days of receipt, unless an extension of 15 days is needed to obtain necessary information. If information is requested, the claimant/provider may be given not less than 45 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 extension period.

2. **A preservice claim involving "urgent care"** may require an oral or expedited process. "Urgent care" is considered to be medical care or treatment for which the time periods for making non-urgent care determinations: a) could seriously jeopardize the life of health of the person or their ability to regain maximum function or, b) would subject the person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the services are urgent, the claimant/provider will be notified of the decision (whether adverse or not), not later than 72 hours after receipt of the claim unless additional information is needed. If further information is necessary, the claimant/provider may be afforded not less than 48 hours from the date of the request, to provide the specified information. Notification of the decision will be provided not later than 48 hours after the earlier of receipt of the specified information or the end of the extension period.

3. **Post-service claims** will be processed within 30 calendar days of receipt. If additional information is needed prior to processing the claim, payment will not be made until the requested information is received. The claim then will be reopened or processed based on the additional information.

An extension also may be given to allow the claimant/provider to submit specified information. The claimant/provider may be given not less than 45 calendar days from the receipt of notice to submit the specified information. A claim determination will be made within 15 calendar days of receipt of information or the end of the extension period.

A claim requiring additional information cannot be completed until the requested information is received. If this information is not received, claims will be denied for "lack of information."

E. PROCEDURE FOR FILING AN APPEAL:

A Covered Person or a person acting on his/her behalf is entitled to appeal preservice or postservice claim or claim appeal decisions.

Internal Appeal:

a. Requesting an Appeal: A request for an internal appeal must be submitted by the claimant within six (6) months of the date the Claim was processed, or Adverse Benefit Determination was made. The request should include the following information:

1) state that it is a request for an appeal;
2) the name and relationship of the person submitting the appeal;
3) the reason for the appeal;
4) any information that might help resolve the issue;
5) the date of service/claim; and
6) if possible, a copy of the Explanation of Benefits (EOB).

This information should be submitted to BCBSNE at the address and telephone number listed on the Covered Person's ID card. Within three days after receipt of a request for an appeal, BCBSNE will provide the claimant an acknowledgment of the receipt of the appeal. This notice will include the name, address and telephone number of a person to contact regarding coordination of the review. A claimant does not have the right to attend, nor to have a representative in attendance at the appeal review, but may submit additional information for consideration.

b. Decision: If the Adverse Benefit Determination was based on a medical judgment, including a Medical Necessity or Investigative determination, BCBSNE will consult with health care professionals with appropriate training and experience in the field of medicine involved in the medical judgment, to make the appeal determination. Identification of the medical personnel consulted, if any, will be provided to the claimant upon written request. The appeal determination will be made by individuals who were not involved in the original determination. Written notification of the decision will be provided to the claimant as follows:

1) for Preservice Claims (other than Urgent Care), within 15 calendar days after receipt;

2) for Postservice Claims involving an Adverse Benefit Determination based on Medical Necessity, Investigative determination or utilization review, within 15 calendar days after receipt; or

3) for all other Post Service Claims, within 15 calendar days after receipt, unless additional time is needed and written notice is provided to the Claimant on or before the 15th day, in which case the decision will be provided within 30 calendar days after receipt.

c. Expedited Appeal: In the case of an Urgent Care Claim, an expedited appeal may be requested orally or in writing. All information, including the decision, will be submitted by telephone, facsimile or the most expeditious method available.

BCBSNE will make a decision and notify the claimant within 72 hours after the appeal is received. Written notification will be sent within the 72-hour period.

Concurrent Care: A request for an expedited appeal of a concurrent care denial must be made within 24 hours of the denial. If requested within this time period, coverage will continue for the health care services pending notification of the review decision, as may be required by law. The decision timeframe will be the same as for other expedited appeals.

d. The decision made pursuant to this appeal is considered a Final Internal Adverse Determination.

2. **Rights to Documentation**: A claimant shall have the right to have access to, and request copies of the documentation relevant to the Claim and Adverse Benefit Determination(s), including any new evidence or rationale considered or relied upon in connection with the Claim on review.

The claimant may submit additional comments, documents or records relating to the Claim for consideration during the appeal process.

3. **Request for External Review:**

a. Standard Review: The claimant may request a review by an Independent Review Organization (IRO) of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination which was based on a judgment as to the Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment. The claimant must exhaust the internal appeal process prior to a request for External Review. The request must be submitted in writing within four (4) months after the date of receipt of a notice of the Final Internal Adverse Benefit Determination. The Covered Person will be required to authorize the release of any of his or her protected health information, including medical records, which may be needed for the purposes of the 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). The request should be submitted to:

Nebraska Department of Insurance
P.O. Box 82089
Lincoln, NE 68501-2089
www.doi.nebraska.gov

Upon receipt of a request for an External Review, the Nebraska Department of Insurance (NDOI) will forward the request to BCBSNE to conduct a preliminary review to determine if it is complete and whether it is eligible for External Review, consistent with applicable law. BCBSNE will conduct this preliminary review within 5 business days of receipt, and notify the NDOI and the claimant of the outcome within one business day. If it is determined that 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. The NDOI may determine that the request is eligible notwithstanding BCBSNE's determination, consistent with state law.

If the request is eligible for External Review, the NDOI will assign an IRO to conduct the review, and notify BCBSNE and the claimant of the assignment within one business day. BCBSNE will forward all documentation and information considered in making the initial

Adverse or Final Internal Adverse Benefit Determination, including a summary of the Claim and explanation for the determination to the IRO within 5 business days. The claimant will also be allowed an opportunity to submit additional information for consideration by the IRO. The IRO shall provide BCBSNE with any information submitted by the claimant, to allow BCBSNE an opportunity to reconsider its original determination.

The IRO shall complete its review and provide the claimant written notification and rationale for its decision within 45 days of receipt of the request for review. No deference shall be given to the prior determinations made by BCBSNE pursuant to the internal appeal process.

b. Expedited External Review: An expedited External Review may be requested at the same time a claimant requests an expedited internal appeal (1.c., above) of an Adverse Benefit Determination concerning:
   1) an Urgent Care Claim; or
   2) a denial on the basis that the requested service or treatment is Investigative, if the Covered Person's Treating Physician certifies in writing that the service or treatment would be significantly less effective if not promptly initiated.

However, the claimant must first exhaust the internal appeal process, unless otherwise waived by BCBSNE or directed by the IRO, consistent with state law.

An expedited External Review may also be requested following a Final Internal Adverse Benefit Determination, if:
   1) the Covered Person has a medical condition where the timeframe for completion of a standard External Review, as described in paragraph 3.a., above, would seriously jeopardize the life or health of the Covered Person or would jeopardize his or her ability to regain maximum function; or
   2) the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay or health care service for which the Covered Person has received emergency services, but has not been discharged from a facility; or
   3) the Final Internal Adverse Benefit Determination is based on a determination that the requested service or treatment is Investigative, if the Covered Person's Treating Physician certifies in writing that the service or treatment would be significantly less effective if not promptly initiated.

The process for coordination of the expedited request between the NDOI, BCBSNE, and the IRO, as described above for a standard review, will be done promptly upon receipt, by telephone, facsimile, or the most expeditious manner available.

An expedited External Review decision shall be made by the IRO within 72 hours after receipt of the request. If notification of the decision to the claimant and BCBSNE was not in writing, the IRO will provide the decision in writing within 48 hours after the oral notification.

An expedited External Review is not available for retrospective Adverse or Final Internal Adverse Benefit Determinations.

c. The decision of the IRO is the final review decision, and is binding upon BCBSNE and the claimant, except to the extent the claimant has other remedies available under applicable federal or state law.

A Covered Person or his or her representative may not file a subsequent request for External Review involving the same Adverse Benefit Determination (initial or Final) for which the Covered Person has already received an External Review decision pursuant to this provision.

4. **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:

1. the application of Utilization Review;
2. a determination that the Service is Investigative;
3. a determination that the Service is not Medically Necessary or appropriate;
4. 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 set forth herein.

ADDITIONAL INFORMATION

The Department of Insurance may be contacted for assistance with the Appeal and External Review process at any time at:

Nebraska Department of Insurance
P.O. Box 82089
Lincoln, NE 68501-2089
(877) 564-7323

PART IX. COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health/dental care coverage under more than one Plan. 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 Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan.

When This Plan is secondary, 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/dental care coverage and apply that calculated amount to any Allowable Expense under this Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount that 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 is plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage. Also, where the Primary Plan is medical payments coverage under a motor vehicle policy, the Secondary Plan shall credit payments from the motor vehicle insurance policy to deductibles, copayments and coinsurance after discounts under the health plan.

A. WITHIN THIS PART, THE FOLLOWING DEFINITIONS APPLY:

1. **Allowable Expense:** A health/dental 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 provide 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, precertification of admissions, and preferred provider arrangements.

2. **Closed Panel Plan:** A Plan that provides health/dental 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.

3. **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 overage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   Plan Includes: group and non-group insurance contracts and subscriber contracts, health maintenance organization (HMO) contracts, Closed Panel Plans; 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; medical benefits coverage in motor vehicle “no fault” and traditional “fault” type contracts; group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; and Medicare or any other federal governmental plan, as permitted by law.
   Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in motor vehicle “no fault” and traditional “fault” contracts; uninsured or underinsured coverage under a motor vehicle policy; specified disease or specified accident coverage; limited benefit health coverage, as defined in state law; school accident coverage; disability income insurance; benefits for non-medical components or long-term care policies; 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.

4. **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.
5. **Secondary Plan:** The Plan that will determine its benefits after those of another Plan and may reduce the benefits so that all Plan benefits do not exceed 100% of the total Allowable Expense.
6. **This Plan:** The part of the contract providing health/dental 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.

Any definitions stated in the Nebraska Coordination of Benefits regulations are hereby incorporated by reference.

B. ORDER OF BENEFITS

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary Plan pays or provides its benefits according to its terms of 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 Plan is always primary unless the provisions of both Plans state 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.

   Each Plan determines its order of benefits using the first of the following rules that apply:

   a. Subscriber and Dependent: The Plan that covers the person as other than a dependent, such as a subscriber/policyholder/employee, 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; or

      a) if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

      for a dependent child who parents are divorced or separated or not living together, whether or not they have ever been married;

      a) if a court decree states that one of the parents is responsible for the dependent 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 commencing after the Plan is given notice of the court decree;

b) if a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph 1) above shall determine the order of benefits;

c) 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 provision of subparagraph 1) above shall determine the order of benefits; or

d) 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;

i. the Plan covering the spouse of the Custodial Parent;
ii. the Plan covering the non-custodial parent; and then
iii. 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 parent of the child, the provision of subparagraph 1) or 2) above shall determine the order of benefits as if those individuals were the parents of the child.

for a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph e. below applies. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parent's plans, the order of benefits shall be determined by applying the birthday rule in paragraph b.1) above, to the dependent child's parent(s) and the dependent's spouse.

Active Employee. Retired or Laid-Off Employee: The Plan that covers a person as an active employee, that is, an employee who is nether retired no laid off, is the Primary Plan. The Plan covering that same person as a retire or 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 rule labeled 4.a. 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/member/employee/retiree or covering the person as a dependent of a subscriber/member/employee/retiree 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 rule labeled 4.a. can determine the order of benefits.

Longer or Shorter Length of Coverage: The Plan that has covered the person longer is the Primary Plan and the Plan that has 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, provides 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 preceding 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.

C. MISCELLANEOUS PROVISIONS

1. If these COB rules do not specifically address a particular situation, We may, at our discretion, rely on the national Association of Insurance Commissioners Coordination of Benefits Model Regulation as an interpretive guide.
2. To properly administer these COB rules, certain facts are needed. The Plan may obtain or release information to any insurance company, organization or person. BCBSNE need not notify, or obtain the consent of, any person to do so. Any person who claims benefits under this Contract agrees to furnish the Plan information that may be necessary to apply these rules and determine benefits payable.
3. If another Plan pays benefits that should have been paid under this Contract, this Plan may reimburse such other Plan any amounts determined to be necessary. Amounts paid to other Plans in this manner will be considered benefits paid under this Contract and This Plan is discharged from liability.
4. If the amount of the benefits paid by This Plan exceeds the amount it should have paid under this Part, then 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 the Subscriber.

PART X. SUBROGATION AND CONTRACTUAL RIGHT TO RECOVERY

A. 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 this Contract, Blue Cross and Blue Shield of Nebraska shall be subrogated to all of the Covered Person's rights of recovery against any person or organization to the extent of the benefits paid. The Subscriber, Covered Person or the person who has a right to recover for a Covered Person (usually a parent or spouse), agrees to make reimbursement under this Part if payment is received from the person who caused the Illness or Injury or from that person's liability carrier.

Our subrogation claim shall be a first priority lien on the full or partial proceeds of any settlement, judgment, or other payment recovered by or on behalf of the Covered Person. This lien applies whether or not the Covered Person has been fully compensated for all of his or her losses, or as provided by applicable law. Blue Cross and Blue Shield of Nebraska's rights under this provision cannot be defeated by allocating the proceeds to nonmedical damages.

B. CONTRACTUAL RIGHT TO REIMBURSEMENT: In the event a Covered Person receives full or partial proceeds from any other source for Covered Services for an Illness or Injury, Blue Cross and Blue Shield of Nebraska has a contractual right of reimbursement to the extent benefits were paid under this 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 and applies whether or not the Covered Person has been fully compensated for all of his or her losses, or as provided by applicable 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 of recovery is in addition to and separate from the subrogation right. Blue Cross and Blue Shield of Nebraska’s rights shall not be defeated by allocating the proceeds to nonmedical damages.

C. When we recover proceeds under this Part for all or part of a claim, amounts previously credited to a Covered Person’s Deductible or Coinsurance liability will be removed. Future claims will be subject to the reinstated Deductible or Coinsurance.

D. 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 our express written consent. The right to recover, whether by subrogation or other reimbursement, shall apply to settlements or recoveries of deceased persons, minor dependents of a Subscriber, incompetent or disabled Subscribers or their incompetent or disabled Eligible Dependents.

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

F. If the Subscriber refuses or fails to comply with this Part, 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.

PART XI. 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 rights 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.

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

Benefits are not payable for services determined to be not compensable due to noncompliance with the terms, rules and conditions under Workers' Compensation laws, or 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 this Contract. If payment is received by the Covered Person for such services, reimbursement must be made, as permitted by law. This reimbursement may be funded from any recovery made from the employer, or the employer's Workers' Compensation carrier. 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.

PART XII. GENERAL PROVISIONS

A. CERTAIN DEFENSES: All statements, in the absence of fraud, made by you or a Covered Person will be deemed representations and not warranties. No such statements will void coverage or reduce the Contract benefits unless contained in the Application.

B. LEGAL ACTIONS: You cannot bring a legal action to recover under the Contract for at least 60 days after written proof of loss is given to us. You cannot start a legal action after three years from the date written proof of loss is required.

C. ADDRESSES FOR NOTICE: **Our address is P.O. Box 3248, Omaha, Nebraska, 68180-0001.** Your address is the most recent address appearing on our records.

D. CONFORMITY WITH STATUTES: Any Contract provision which on its effective date, is in conflict with the law of the federal government or the state of Nebraska is hereby amended to conform to the minimum requirements of such law.

E. TIME LIMIT ON CERTAIN DEFENSES: After two years from the Contract effective date, no misstatements, except fraudulent misstatements made in the Contract Application will be used to void the Contract or deny a claim for loss incurred after the expiration of such two-year period. No claim for loss that starts more than 365 days after the Contract effective date will be reduced or denied on the grounds that a condition not excluded from coverage existed prior to such effective date.

F. BLUE CROSS AND BLUE SHIELD OF NEBRASKA MEMBERSHIP: When this Contract becomes effective, you become a Member of GoodLife Partners, Inc. a mutual holding company and the overall parent company of Blue Cross and Blue Shield of Nebraska, Inc. You have the right to vote at the Annual Meeting of Members held at the Blue Cross and Blue Shield of Nebraska home office in Omaha. The Meeting is held at 4:00 p.m. on the second Monday of February each year. If you do not attend the Meeting, you may appoint another Member as your proxy to vote for you. To have another person vote for you, you must appoint that person in writing, and file that appointment with us at least five days before the Meeting. If you do not attend the Meeting, and do not appoint another person as your proxy, the Chairperson of the Board of Directors of Blue Cross and Blue Shield of Nebraska, or in the absence of the Chairperson, a person the Chairperson appoints, will be your proxy to vote for you on all matters coming before the Meeting. This proxy will be valid as long as this Contract remains in force, unless you revoke it.

G. INDEPENDENT CORPORATION: Subscriber hereby expressly acknowledges his or her understanding that this Contract constitutes a contract solely between Subscriber and the Plan, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting BCBSNE to use the Blue Cross and/or Blue Shield Service Marks and that BCBSNE is not contracting as the agent of the Association. Subscriber further acknowledges and agrees that he or she has not entered into this Contract based upon representations by any person other than BCBSNE and that no person, entity, or organization other than BCBSNE shall be held accountable or liable to Subscriber for any of BCBSNE's obligations created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of BCBSNE other than those obligations created under other provisions of this Contract.

H. NON-WAIVER: Neither the acceptance of premium nor the payment of claims shall constitute a waiver of available defenses.

I. LIMITATIONS OF DAMAGES: The entire liability of Blue Cross and Blue Shield of Nebraska shall not exceed the amount of benefits provided by this Contract, regardless of the form of the action. In no event shall we be liable for consequential, incidental, special or indirect damages regardless of whether it has been advised of the possibility of such damages.

PART XIII. DEFINTIONS

The definitions contained in this glossary are of terms used in this Contract.

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 we use to calculate our 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.

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 this Contract, Nebraska law and the direction of BCBSNE.

BCBSNE: Blue Cross and Blue Shield of Nebraska.

Certification (**Certified**)**:** A determination that Services are appropriate under the terms of the Contract.

Certification also refers to 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 you and BCBSNE, including your Application, your Schedule of Benefits, this document and any attachments or endorsements.

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 this Contract underwritten and administered by BCBSNE.

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

Deductible: An amount of Allowable Charges which must be met by the Covered Person each calendar year for Covered Services before benefits are payable by this 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 this Contract as long as the child is, and remains, both:

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

- dependent upon 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 Us. Any extended coverage under this paragraph will be subject to all other provisions of this 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.

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 or with an On-site Plan as part of the Preferred Provider network.

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.

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.

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

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

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.

Noncovered Services: Services that are not payable under this 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.

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 we use to calculate BCBSNE's payment for Covered Services to an Out-of-network Provider. This amount will be based on the Contracted Amount for Nebraska 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 On-site Plan's preferred 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.

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, Coinsurance or percentages payable, special benefits, maximums and limitations of coverage. It also indicates the type of Membership Unit selected. 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 this Contract.

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