Delta Dental of Nebraska

Delta Dental Individual and Family℠

Delta Dental Gold + Kids Plan

Delta Dental Individual and Family[SM]- Adult Gold + Kids Plan

Thank you for choosing Delta Dental to protect your smile!

This Dental Benefit Plan is an insurance policy covering certain dental benefits and is issued by Delta Dental of Nebraska, referred to as "Delta Dental" in this document. We consider this document our contract with "you"—the person who enrolled in this policy and is also known as the "subscriber." You, your spouse or any dependents on the policy, will be referred to as "covered persons" throughout this document.

This document is your policy, which is a contract for dental benefits coverage. It is important that you read this document and contact us if you have any questions. We also encourage you to keep this document for reference if you have questions about your dental benefits coverage.

The application you completed with your enrollment is part of this policy. If any part of your application is wrong, please contact Delta Dental Customer Service. Wrong information may affect your coverage. If the answers are incorrect or untrue, we may have the right to deny benefits or rescind your policy. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Delta Dental of Nebraska is the health plan that issued you this Dental Benefit policy. The benefits under this policy are guaranteed by Delta Dental of Nebraska under this contract. If you enrolled into this policy and had prior Individual and Family coverage through Delta Dental of Nebraska, we will review the claims that were previously incurred and submitted when we determine your benefits under this policy.

YOUR RIGHT TO EXAMINE AND CANCEL
You may cancel this contract by returning the contract, with written notification of your cancelation to Delta Dental of Nebraska, P.O. Box 1886, Indianapolis, IN 46206-1886. Cancelation notice must be given by mail and needs to be properly addressed, postage prepaid, and postmarked no later than **ten days** after you received this contract. Delta Dental will void your policy from its effective date. Delta Dental will also return the difference between any premiums paid by you and any benefits paid by Delta Dental on your behalf or on behalf of any of the covered persons under this contract.

DELTA DENTAL OF NEBRASKA

BY: Nadia C. Martyn

TITLE: Assistant Secretary

DELTA DENTAL OF NEBRASKA

AND BY: Tamera K. Roth

TITLE: President

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Delta Dental Individual and Family

Delta Dental of Nebraska will pay the benefits described in this Policy subject to its provisions.

Delta Dental of Nebraska does not discriminate or restrict access to its dental policies on the basis of sex, including gender identity. Delta Dental of Nebraska assures that services that are ordinarily or exclusively available to individuals of one sex, will not be denied to a transgender individual based on the sex assigned to that individual at birth.

By paying the first premium and accepting this Policy, the Subscriber agrees to be bound by the terms of this Policy.

This Policy is a legal contract between the Policy Owner and Delta Dental of Nebraska. This Policy is subject to the laws of the State of Nebraska.

PREMIUM CALCULATIONS AND PAYMENT

Premiums are payable on a monthly basis, unless Delta Dental agrees to some other payment schedule. Premiums must be paid electronically as agreed to by Delta Dental or to Delta Dental at the following address:

Delta Dental of Nebraska
PO Box 74008401
Chicago IL 60674-8401

The payment of any premium will keep the coverage in force to the next premium due date, subject to the Grace Period provision of the Contract.

Delta Dental may change the premium for insurance provided under this Contract by giving the Subscriber a written notice at least 31 days prior to any change.

CONTRACT PROVISIONS

ENTIRE CONTRACT: This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of Delta Dental and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred or disability, as defined in the Policy, commencing after the expiration of such two-year period. (b) No claim for loss incurred or disability, as defined in the Policy, commencing after two years from the date of issue of this Policy shall be reduced or denied on the ground that disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

GRACE PERIOD: A Grace Period of 90 days will be granted for the payment of premiums after the first

premium, during which Grace Period, the coverage under this Contract will continue in force.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this Contract prior to the expiration of 60 days after written proof of loss has been furnished in accordance with this Policy. No such action will be brought after the expiration of three years after written proof of loss is required to be furnished.

NOTICE OF CLAIM: Written notice of claim must be given to Delta Dental within twenty days after the occurrence or commencement of any loss covered by the Policy or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Subscriber or the beneficiary to Delta Dental at PO Box 1886, Indianapolis, IN 46206-1886 or to any authorized agent of Delta Dental, with information sufficient to identify the Subscriber, shall be deemed notice to Delta Dental.

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

PROOF OF LOSS: Written proof of loss must be furnished to Delta Dental at its office, in case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which Delta Dental is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time and if such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Subscriber. Any other accrued indemnities unpaid at the Subscriber's death may, at the option of Delta Dental, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Subscriber.

CONFORMITY WITH STATE AND FEDERAL LAW: Any provision of this Contract, which on its Effective Date, is in conflict with the laws of the federal government or the state in which the Subscriber resides on such date is hereby amended to conform to the minimum requirements of such law.

CLERICAL ERROR: Clerical error by the Subscriber will not invalidate insurance otherwise validly in force nor continue insurance otherwise terminated.

PHYSICAL EXAMINATIONS AND AUTOPSY: Delta Dental at its own expense shall have the right and opportunity to examine the covered person when and as often as it may reasonably require during the

pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

CONTRACT TERM: This Contract continues until December 31 each year, so long as the premium is paid, subject to the Grace Period.

You may cancel this policy by giving written or verbal notice to Delta Dental. When notifying Delta Dental, the notice must be submitted to the address or phone number as stated on the back of your ID card or found in this Policy. When notice is given, the cancellation date can be effective as soon as the first of the following month. Delta Dental reserves the right to terminate the policy, in whole or in part, by giving you written notice at least 31 days advanced notice. Termination or cancellation of the policy will result in loss of benefits for all covered persons. If the policy is terminated or cancelled, the rights of the covered persons are limited to covered expenses incurred before termination or cancellation.

REINSTATEMENT: If any renewal premium is not paid within the time granted the Subscriber for payment, a subsequent acceptance of premium by Delta Dental or by any agent duly authorized by Delta Dental to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. The reinstated policy shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid but not to any period more than sixty days prior to the date of reinstatement.

CHANGE OF BENEFICIARY: Unless the Subscriber makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Subscriber and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Policy, to any change of beneficiary or beneficiaries, or to any other changes in this Policy.

PROVISIONS MADE PART OF THE CONTRACT

The provisions described in the Table of Contents are part of this Contract. Amendments, if any, adding or changing the provisions of the Summary are also made part of this Contract.

Notice of Non-Discrimination and Accessibility Requirements

Delta Dental of Nebraska, collectively referred to herein as “Delta Dental of Nebraska,” complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)).

Delta Dental of Nebraska does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental of Nebraska provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Delta Dental of Nebraska provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call the number on the back of your ID card.

If you believe that Delta Dental of Nebraska has failed to provide these services or discriminated in another way on the

basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting Delta Dental of Nebraska, Attn:Chief Compliance Officer, 500 Washington Ave South, Suite 2060 Minneapolis, MN, 55415, 612-224-3300 or 877-268-3384, fax:612- 460-3102; email: legal@deltadentalmn.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, please call the number on the back of your ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Notifications

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-448-3815. (Spanish)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-448-3815. (Hmong)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-448-3815. (Cushite)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-448-3815. (Vietnamese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-448-3815. (Chinese)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-448-3815. (Russian)

ໂປດຊາບ: ຖ້ າວ່ າ ທ່ ານເວ ົ້ າພາສາ ລາວ, ການບໍ ລິ ການຊ ່ ວຍເຫ ຼ ືອ ດ ້ ານພາສາ, ໂດຍ ບ ເສ ັ ຽ ຄ ່ າ, ແມ ່ ນມ ້ ອມໃ ຫ ້ ທ ່ ານ. ໂທ 1-800-448-3815. (Laotian)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800- 448-3815. (Amharic)

ဟ်သူဉ်ဟ်သး– နမ့ါကတိၤ ကညီ ကျိာ်အယိ. နမၤနှ၊ ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1-800-448-3815. (TTY: 711). (Karen)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-448-3815. (German)

ملحوظة: إذا كنت تتحدث اذكر لغتلا، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-448-3815 (رقم.) (Arabic)

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-448-3815. (French)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-448-

3815.번으로 전화해 주십시오. (Korean)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-448-3815. (Tagalog)

ئاگاداری (Kurdish) 1 بکە. .هەتسەدرهب-800-448-3815. بھ پ

توجھ :اگر بھ زبان فارسی گفتگو می دینک، تسھیلات زبانی بصورت رایگان برای شما .بگیرید تماس 1-800-553-(Persian / Farsi) 9536 با ف می باشد

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-448- 3815.まで、お電話にてご連絡ください。(Japanese)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-448-3815. (Bantu)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-448-3815. (Swahili)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-800-448-3815. (Norwegian)

សូមប្រុងប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយ [ភាសាខ្មែរ], សេវាជំនួយភាសាដោយឥតគិតថ្លៃ, ដែលអ្នកអាចប្រើប្រាស់បាន។ សូមហៅទូរស័ព្ទ 1-800-448-3815. (Cambodian/Khmer)

ध्यानाकर्षण: यदि तपाईं [नेपाली] बोल्नुहुन्छ भने, नि:शुल्क रुपमा तपाईंलाई भाषा सहायता सेवाहरु उपलब्ध छन्। 1-800-448-3815. मा कल गर्नुहोस्। (Nepali)

SUMMARY OF DENTAL BENEFITS

Essential Health Benefits - Pediatric Dental (Must be 18 years old or younger at the time the policy is issued or renewed)

Annual Out of Pocket Maximum (per child/all covered children) $400/ $800

Annual Deductible per child per year $50
(Does not apply to Diagnostic and Preventive Services)

Dentally Necessary Orthodontic Care Maximum (per course of treatment) none

Service Type	Participating Dentist	Nonparticipating Dentist
Diagnostic and Preventive Services*	100%	100%
Basic Services	50%	50%
Endodontics/ Periodontics/ Oral Surgery	50%	50%
Major Restorative Services	50%	50%
Prosthodontics and Implant services	50%	50%
Dentally Necessary Orthodontic Care	50%	50%

* The Deductible does not apply to Diagnostic and Preventive Services

Adult Dental Benefits – Non-Essential Health Benefits (Must be 19 years older or older at the time the policy is issued or renewed)

Delta Dental Gold

Annual Maximum (per member) $1,000

Annual Deductible (per member) $50
The Deductible does not apply to Diagnostic and Preventive Services.

Service Type	Participating Dentist	Nonparticipating Dentist
Diagnostic and Preventive Service	100%	100%
Basic Services	50%	50%
Endodontics/ Periodontics/ Oral Surgery	50%	50%
Major Restorative Services*	25%	25%
Prosthodontic Repairs and Adjustments*	25%	25%
Prosthodontic and Implant Services*	25%	25%

*A 12 month waiting period must be satisfied before benefits can be received

Annual Maximums

Adult Dental Benefits – Non-Essential Health Benefits:
Delta Dental pays up to a maximum of $1,000.00 for each Covered Person per Coverage Year subject to the fee schedule amounts and the coverage percentages identified below. Unused Annual Maximums may not be carried over to future coverage years.

Deductible

Pediatric Dental Benefits – Essential Health Benefits: There is a $50 deductible per Covered Person each Coverage Year. The deductible does not apply to any Diagnostic and Preventive Services within the Essential Health Benefits.

Adult Dental Benefits – Non-Essential Health Benefits:
There is a $50 deductible per Covered Adult each Coverage Year. The deductible will not apply to Diagnostic and Preventive Services.

Coverage Year

Your Coverage Year is January 1 through December 31. A Coverage Year is a 12-month period in which deductibles and annual maximums apply. If you enroll after January 1, the Coverage Year for your first year will be from your effective date through December 31 and will begin again the following January 1.

DESCRIPTION OF COVERED SERVICES

Pre-Treatment Estimates (Estimate of Benefits)
If a covered person's dental care involves major restorative, periodontic, prosthodontic, implant or orthodontic care, you or your dentist should consider getting a pre-treatment estimate from Delta Dental.

- While a pre-treatment estimate is recommended, it is not required.
- If you or your dentist request a pre-treatment estimate, you and your dentist will be informed of what benefits you have and if the treatment is a covered service via a pre-treatment estimate statement.
- The pre-treatment estimate statement will also outline amounts you will have to pay to the dentist, such as coinsurance, deductibles, and non-covered services.
- The pre-treatment estimate allows the dentist and you to make any necessary financial arrangements before your treatment begins.
- Please be aware that pre-treatment estimates do not prior authorize the treatment, nor determine its dental or medical necessity, except in the case of pediatric veneers, implants or orthodontic treatment (see "Dental Necessity" below). The estimated payment is based on your current eligibility and contract benefits in effect at the time of the estimate.
- A pre-treatment estimate is an estimate only. Final payment will be based on the claim that is submitted once the treatment is completed. Submission of other claims, a change in eligibility, a change in coverage, or other coverage you have may alter the payment.

Benefits
This policy covers the following procedures when they are lawfully performed by or under the appropriate supervision of a duly licensed dentist or physician and when customary as determined by the standards of generally accepted dental practice.

ONLY the services listed in this policy are covered. Services covered are subject to the limitations and exclusions as described in this booklet. If there is more than one professionally acceptable treatment for your dental condition, and the policy otherwise covers the services, the policy will cover the least expensive.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN THE *DELTA DENTAL PPO™* AND DELTA DENTAL PREMIER®

NETWORKS PRIOR TO RECEIVING DENTAL CARE.

Dental Necessity
Delta Dental performs dental necessity reviews to determine whether a service submitted for payment or benefit under this Plan is a dental procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. Dental services may be subject to pre-payment clinical review of dental records. It is Delta Dental's policy that a licensed dentist reviews claims where a dental necessity determination is made, and denies the oral health service where dental necessity has not been demonstrated. Denials based solely on coverage specifications, limitations, and exclusions under the enrollee's contract are not considered utilization review and not evaluated for dental necessity.

Delta Dental evaluates dental procedures submitted to determine if the procedure is a covered benefit under your dental plan. Your dental Plan includes a preset schedule of dental services that are eligible for benefit by the Plan. Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this plan. While these services may be necessary for your dental condition, they may not be covered by us. You are responsible for any costs that are not covered by the Plan or exceed the frequency of the Plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for dental services that are not covered or benefited by the Plan. The decision as to what dental care treatment is best for you is solely between you and your dentist.

EXCEPTION: Claims for pediatric veneers, implants and orthodontic care will be reviewed to determine if the care is Dentally Necessary Care. See the "Orthodontic Care" section of this booklet for more information on Orthodontic Dental Necessity. If it is determined the care is not Dentally Necessary Care, it will not be covered.

ONLY those services listed are covered. Deductibles and maximums are listed under the Summary of Dental Benefits. Services covered are subject to the limitations within the Description of Covered Services section(s) described below. For estimates of covered services, please see the "Pretreatment Estimate" section of this Policy.

Description of Covered Services for Adult Members – Non-Essential Health Benefits

We cover the following dental care services for members ages 19 and older when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, we will cover the least expensive.

Waiting Periods

New Covered Persons will be subject to a 12-month waiting period for Major Restorative and Prosthetic Services.

Diagnostic & Preventive Services for adult members

Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Radiographs (X-rays)

- **Bitewings** - Covered at 1 series of bitewings every 2 calendar years.
- **Full Mouth (Complete Series) or Panoramic –** Covered 1 time per 60-month period.
- **Periapical(s)** – 4 single X-rays are covered per 12-month period.
- **Occlusal** – Covered at 2 series per 24-month period.

Prophylaxis, Scaling in presence of generalized gingival inflammation after an oral evaluation, or Periodontal Maintenance - Any combination of these procedures is covered 2 times per calendar year.

Basic Services for adult members

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

- **Anterior (front) Teeth** - Treatment to restore decayed or fractured permanent or primary anterior (front) teeth.
  Posterior (back) Teeth - Treatment to restore decayed or fractured permanent or primary posterior (back) teeth. These benefits shall be limited to the same surfaces and allowances for amalgam (silver filling). The patient must pay the difference in cost between Delta Dental's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

LIMITATION: Coverage for amalgam or composite restorations shall be limited to only 1 service per tooth surface per 24-month period.

General Anesthesia, Intravenous Conscious Sedation and IV Sedation – Covered when performed in conjunction with complex surgical service.

Recement inlay, onlay, or crown

Endodontics for adult members

Endodontic Therapy on Primary Teeth

- **Pulpal Therapy**
- **Therapeutic Pulpotomy**

Endodontic Therapy on Permanent Teeth

- **Root Canal Therapy**

LIMITATION: All of the above procedures are covered 1 time per tooth per lifetime.

Other Covered Endodontic Services

- **Partial Pulpotomy for Apexogenesis**
- **Bone Graft**

Periodontics for adult members

Basic Non-Surgical Periodontal Care - Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- **Periodontal scaling & root planing** - Covered 1 time per 36 months.
- **Full mouth debridement** - Covered 1 time per lifetime.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.

Complex Surgical Periodontal Care - Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this plan.

- **Gingivectomy/gingivoplasty**
- **Gingival flap**
- **Osseous surgery**
- **Bone replacement graft**
- **Pedicle soft tissue graft**
- **Free soft tissue graft**
- **Subepithelial connective tissue graft**
- **Soft tissue allograft**
- **Combined connective tissue and double pedicle graft**
- **Distal/proximal wedge**

LIMITATION: Only 1 complex surgical periodontal service is a benefit covered 1 time per 36-month period per single tooth or multiple teeth in the same quadrant.

Oral Surgery for adult members

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Other Surgical Procedures

- Alveoloplasty
- Tooth re-implantation of accidentally displaced tooth and surgical repositioning of teeth.
- Incision and drainage of abscess.

- Exposure of unerupted tooth.
- Procedures to aid eruption of impacted teeth
- Incision of oral tissue.
- Suture of recent small wounds up to 5 cm.

Major Restorative Services for adult members* 12 month waiting period applies

Gold foil restorations - Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances. The patient must pay the difference in cost between Delta Dental's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit. Covered 1 time per 24-month period.

Inlays - Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

Onlays and/or Permanent Crowns - Covered 1 time per 5-year period per tooth

Crown Repair - Covered 1 time per 12-month period per tooth.

Prosthodontics and Implant services for adult members* 12 month waiting period applies

Reline and Rebase - Covered 1 per 24-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) - Covered 1 per 6-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Denture Adjustments - Covered 2 times per 12-month period:

- when the denture is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the denture.

Partial and Bridge Adjustments - Covered 2 times per 24-month period:

- when the partial or bridge is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) - Covered 1 time per 5-year period:

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (denture or partial)

and the existing appliance needs replacement because it cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) - Covered 1 time per 5-year period:

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last 5 years;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Implant Supported Fixed and Removable Prosthetic (Crowns, Bridges, Partials and Dentures) - A restoration that is retained, supported and stabilized by an implant. Implants and related services are NOT covered.

LIMITATION: This procedure receives an optional treatment benefit equal to the least expensive professionally acceptable treatment. The additional fee is the patient's responsibility. For example: A single crown to restore one open space will be given the benefit of a Fixed Partial Denture Pontic (one unit). The optional benefit is subject to all contract limitations on the benefited service.

General Exclusions Applicable to Adult Members – Non-Essential Health Benefits
In addition to specific exclusions set forth in other sections of this Policy, coverage is NOT provided for:

a) Dental services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a covered person who is eligible for or receiving Medical Assistance.

b) Dental services or health care services not specifically covered under the Dental Plan Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).

c) New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of Delta Dental, an established scientific basis for recommendation.

d) Dental services performed for cosmetic purposes. NOTE: Dental services are subject to post-payment review of dental records. If services are found to be cosmetic, we reserve the right to collect any payment and the member is responsible for the full charge.

e) Dental services completed prior to the date the Covered Person became eligible for coverage.

f) Services of anesthesiologists.

g) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.

h) Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction

with complex surgical services.

i) Dental services performed other than by a licensed dentist, licensed physician, his or her employees.

j) 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.

k) Artificial material implanted or grafted into or onto bone or soft tissue, including implant services and associated fixtures, or surgical removal of implants.

l) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.

m) Orthodontic treatment services.

n) Case presentations, office visits and consultations.

o) Incomplete, interim or temporary services.

p) Corrections of congenital conditions during the first 24 months of continuous coverage under this Plan.

q) Athletic mouth guards, enamel micro-abrasion and odontoplasty.

r) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the policy.

s) Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.

t) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.

u) Intentional reimplantation.

v) Apicoectomy.

w) Root Amputation.

x) Guided Tissue Regeneration.

y) Apexification.

z) Retrograde filling.

aa) Hemisection.

bb) Provisional splinting, temporary procedures or interim stabilization of teeth.

cc) Surgical exposure of impacted or unerupted tooth for orthodontic reasons.

dd) Restorative cast post/core or core build-up.

ee) Canal prep & fitting of preformed dowel & post.

ff) Occlusal procedures, including occlusal guard and adjustments.

gg) The replacement of an existing partial denture with abridge.

hh) Initial installation of full or partial dentures, implants or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a Covered Person under this Plan. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this Plan for more than 24 months.

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

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

kk) Coverage shall be limited to the least expensive professionally acceptable treatment.

ll) Resin infiltration of incipient smooth surface.

mm) Bacteriologic tests.

nn) Cytology sample collection.

oo) Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.

pp) Oral hygiene instruction.

qq) Restorative cast post/core or core build-up, including pins and posts.

rr) Occlusal procedures.

ss) Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.

tt) Implant maintenance or repair to an implant or implant abutment.

uu) Adjunctive diagnostic tests.

vv) Incomplete root canals.

ww) Cone beam images.

xx) Anatomical crown exposure.

yy) Temporary anchorage devices.

zz) Sinus augmentation.

aaa) Brush biopsy and the accession of a brush biopsy.

bbb) Services related to diagnosis and treatment of Temporomandibular Disorder.

ccc) Restorations placed for preventive or cosmetic purposes.

ddd) Inlays, onlays and crowns placed for preventive or cosmetic purposes.

eee) 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.

fff) Fluoride.

ggg) Space Maintainers and related services.

hhh) Sealants.

iii) Oral Hygiene instructions.

jjj) Sialography.

kkk) Interpretation of Diagnostic Images

Description of Covered Services for Pediatric Members – Essential Health Benefits

We cover the following dental care services for members through the year in which the covered person turns 19 years of age when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, we will cover the least expensive.

Diagnostic & Preventive Services for pediatric members

Oral Evaluations - Any type of evaluation, except problem focused oral evaluations, is covered 2 times per calendar year.

Problem Focused Oral Evaluations and Re-evaluations

Radiographs (X-rays)

- **Bitewings** - Covered at two sets of four supplemental bitewing X-rays per calendar year
- **Full Mouth (Complete Series) or Panoramic** – Covered 1 time per 60-monthperiod.
- **Periapical(s)**
- **Occlusal**

- **Extraoral Film**

Dental Cleaning (Prophylaxis), including scaling of moderate or severe gingival inflammation after an oral evaluation – Covered 2 times per calendar year.

Fluoride Treatment (Topical application of fluoride) - Covered 2 times per calendar year.

Silver Diamine Fluoride - Covered 2 times per calendar year, per tooth.

Fluoride Varnish - Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered 1 time per 24-month period for permanent first and second molars.

Space Maintainers

Recement and Removal of Space Maintainers

Pulp Vitality Tests

Emergency Treatment

Basic Services for pediatric members

Consultations (other than dentist providing treatment)

Office Visits after regularly scheduled office hours

Amalgam (silver) Restoration

Composite (white) Resin Restorations. Treatment to restore decayed or fractured permanent or primary teeth. Coverage shall be limited to 1 service per tooth surface per 24-month period.

Therapeutic Drug Injection

Internal Bleaching

Veneers, when dentally necessary

Endodontics for pediatric members

Endodontic Therapy on Primary Teeth

- Pulpal Therapy
- Therapeutic Pulpotomy

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments

- Apicoectomy
- Hemisection
- Retrograde filling
- Partial Pulpotomy for apexogenesis - Covered 1 time per lifetime on permanent teeth only.
- Pulp Capping
- Treatment of Root Canal Obstruction
- Internal Root Repair of Perforation Defects

Periodontics for pediatric members

Basic Non-Surgical Periodontal Care – Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Full mouth debridement -- Covered 1 time per lifetime
- Periodontal Maintenance – Covered 4 times per calendar year. This limit will be reduced by the number of dental cleanings received during the calendar year.
- Periodontal scaling & root planing - Covered 1 time per quadrant per 24 months

Complex Surgical Periodontal Care - Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty/mucogingivoplastic surgery
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pediclegraft;
- Distal/proximal wedge - Covered on natural teeth only

LIMITATION: Each complex surgical periodontal service is covered per 36-month period per single tooth or multiple teeth in the same quadrant.

Crown Lengthening – Covered once per lifetime.

Chemotherapeutic Agents

Oral Surgery for pediatric members

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Other Complex Surgical Procedures

- Alveoloplasty

Other Oral Surgery Procedures.

- Incision and drainage of abscess (intraoral soft tissue)
- Coronectomy
- Tooth reimplantation – accidentally evulsed or displaced tooth
- Suture of recent small wounds up to 5 cm

General Anesthesia, Intravenous Conscious Sedation and IV Sedation - Covered when performed in conjunction with complex surgical service.

Major Restorative Services for pediatric members

Gold foil restorations – Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances**.** The patient must pay the difference in cost between Delta Dental's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

Inlays – Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

Onlays and/or Permanent Crowns - Covered 1 time per 5-year period per tooth if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only.

Pre-fabricated or Stainless Steel Crown - Covered 1 time per 60-month period for children through the age of 14.

Recement Inlay, Onlay and Crowns – Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair – Covered 1 time per 12-month period per tooth when the submitted narrative from the treating dentist supports the procedure.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface - Covered 1 time per 5 years when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown – covered 1 per tooth every 60 months.

Occlusal Guards – Covered 1 per 12 months for members age 13 and older.

Prosthodontic and Implant Services for pediatric members

Tissue conditioning

Reline and Rebase – Covered 1 per 36-month period;

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Clasp(s)

Replacement of Broken Artificial Teeth - Covered 2 times per 24-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge); and
- when the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments

Partial and Bridge Adjustments

Removable Prosthetic Services (Dentures and Partials) – Covered 1 time per 5-year period;

- for the replacement of extracted (removed) permanent teeth;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) - Covered 1 time per 5-year period:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have elapsed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

LIMITATION: If there are multiple missing teeth, a removable partial denture may be the benefit since it would be the least costly, commonly performed course of treatment. The optional benefit is subject to all contract limitations on the covered service.

Recement Fixed Prosthetic

Single Tooth Implant Body, Abutment and Crown - Covered 1 time per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Only covered, when determined to be dentally necessary.

LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a pretreatment estimate be requested to estimate the amount of payment prior to beginning treatment.

Orthodontic Care

Orthodontic Treatment is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover orthodontic care that is considered Dentally Necessary Orthodontic Care. You should submit your treatment plan to us before you start any orthodontic treatment to make sure it is covered under this policy.

Dentally Necessary Orthodontic Care

To be considered Dentally Necessary Orthodontic Care, at least one of the following criteria must be met:

- Accident causing a severe malocclusion
- Injury causing a severe malocclusion
- Condition that was present at birth causing a severe malocclusion
- Medical condition causing a severe malocclusion
- Facial skeletal condition causing a severe malocclusion

Orthodontic treatment may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts/models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Complex Surgical Procedures – surgical exposure of impacted or unerupted tooth for orthodontic reasons; or surgical repositioning of teeth.

Note: Treatment in progress (appliances placed prior to being covered under this policy) will be benefited on a pro-rated basis.

Orthodontic Exclusions

Coverage is NOT provided for:

- Monthly treatment visits that are inclusive of treatment cost;
- Repair or replacement of lost/broken/stolen appliances;
- Orthodontic retention/retainer as a separate service;
- Retreatment and/or services for any treatment due to relapse;
- Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
- Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, payments are made over the course of your treatment. You must have continuous coverage under this plan in order to receive ongoing payments for your orthodontic treatment.

Before treatment begins, the treating dentist should submit a pre-treatment estimate to us. A pre-treatment Estimate Statement will be sent to you and your dentist indicating the estimated maximum allowed amount, including any amount (coinsurance) you may owe.

Reconstructive Surgery

Benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such dental procedure is performed on a covered child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, provided however, that such services are dental reconstructive surgical services.

Cleft lip and Cleft palate

Benefits for inpatient or outpatient expenses arising from dental services up to age 18, including orthodontic and oral surgery services, involved in the management of birth defects known as cleft lip and cleft palate. If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this plan shall be primary and the other policy or contract shall be secondary.

General Exclusions Applicable to Pediatric Members – Essential Health Benefits

In addition to specific exclusions set forth in other sections of this Policy, coverage is NOT provided for:

a) Dental services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a Subscriber or Dependent who is eligible for or receiving Medical Assistance.

b) Dental services or health care services not specifically covered under the Summary of Dental Benefits (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).

c) New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of Delta Dental, an established scientific basis for recommendation.

d) Dental services performed for cosmetic purposes. NOTE: Dental services are subject to post-payment review of dental records. If services are found to be cosmetic, we reserve the right to collect any payment and the member is responsible for the full charge.

e) Dental services completed prior to the date the Covered Person became eligible for coverage.

f) Services of anesthesiologists.

g) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.

h) Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

i) Dental services performed other than by a licensed dentist, licensed physician, his or her employees.

j) 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.

k) Sialography

l) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth, except as noted as specifically covered.

m) Interpretation of Diagnostic Images.

n) Case presentations, office visits and consultations.

o) Incomplete, interim or temporary services.

p) Pin Retention.

q) Athletic mouth guards, enamel microabrasion and odontoplasty.

r) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the policy, excepted as stated as covered in the previous section.

s) Bacteriologic tests.

t) Cytology sample collection.

u) Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.

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

w) Services for the replacement of an existing partial denture with abridge.

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

y) Provisional splinting, temporary procedures or interim stabilization.

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

aa) Oral hygiene instruction.

bb) Occlusal procedures.

cc) Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.

dd) Diagnostic casts.

ee) Incomplete root canals.

ff) Cone beam images.

gg) Anatomical crown exposure.

hh) Temporary anchorage devices.

ii) Sinus augmentation.

jj) Brush biopsy and the accession of a brush biopsy.

kk) Restorations placed for preventive or cosmetic purposes.

ll) Inlays, onlays and crowns placed for preventive or cosmetic purposes.

mm) 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.

nn) Pulpal regeneration.

oo) Apexification.

pp) Root Amputation.

qq) Services related to diagnosis and treatment of Temporomandibular Disorders.

Post Payment Review
Dental services are evaluated after treatment is rendered for accuracy of payment, benefit coverage and potential fraud or abuse as defined in the Health Insurance Portability and Accountability Act of 1996 - Public Law 102-191. Any payments for dental services completed solely for cosmetic purposes or payments for services not performed as billed, are subject to recovery. Delta Dental's right to conduct post payment review and its right of recovery exists even if a Pretreatment Estimate was submitted for the service.

ELIGIBILITY

Covered Persons under this Policy are:

Subscriber

a) All Subscriber who have met the eligibility requirements as established and stated within this Dental Benefit Plan Summary under Effective Date of Coverage; and

b) Is a Nebraska resident.

Dependents, if Dependent coverage is elected

A. Spouse, meaning:

1. Married;

2. Legally separated;
3. Qualified domestic partner of a Subscriber, if all of the following criteria are met:
   a. are not related by blood closer than permitted under applicable marriage laws;
   b. are not married and do not have any other domestic partners;
   c. are at least eighteen (18) years of age and have the capacity to enter into a contract;
   d. share a residence;
   e. are jointly responsible to each other for the necessities of life and, if asked, could produce documentation of at least three of the following items as evidence of joint responsibility:
      - joint mortgage or joint tenancy on a residential lease;
      - joint bank account;
      - joint liabilities (e.g., credit cards or car loans);
      - joint ownership of significant property (e.g., cars, land, etc.);
      - naming of each other a primary beneficiary in wills or life insurance policies;
      - written notarized agreements or contracts regarding the relationship, showing mutual support obligations, or joint ownership of assets acquired during the relationship;
      - commitment to a long-term relationship with the intention of remaining together indefinitely.

B. Dependent children until the end of the year in which a child turns 26 years of age, including:
   1. Natural-born and legally adopted children (including children placed with you for legal adoption. NOTE: A child's placement for adoption terminates upon the termination of the legal obligation of total or partial support.
   2. Children of the domestic partner of the Subscriber. NOTE: Children of a Domestic Partner are eligible only as long as the Domestic Partner is covered, and they must qualify as a Domestic Partner's Dependent for Federal tax purposes.
   3. Stepchildren who reside with you.
   4. You or your covered spouse's grandchildren who are financially Dependent on you and reside with you continuously from birth.
   5. Children for whom you are the legal guardian.
   6. Children who are required to be covered by reason of a Qualified Medical Child Support Order.
   7. Children who become disabled prior to reaching the policy's limiting age if:
      - they are primarily Dependent upon you; and
      - are incapable of self-sustaining employment because of developmental delay, mental illness or mental disorder or physical disability.

Under the Affordable Care Act ("ACA"), pediatric dental coverage for children is provided up to age 19. Once an individual no longer qualifies for pediatric dental coverage under the ACA, Delta Dental of Nebraska can provide dental care services for adult members ages 19 and older if they choose to enroll in an individual plan through Delta Dental.

Newborn and Adopted Child Coverage

Newborn infants (including a newborn grandchild of a covered grandparent) may be covered, regardless of when notice is received by Delta Dental. If you enroll a child by his or her 3rd birthday (or within 31 days after the birthday), then you will not be required to make retroactive premium payments for the child and the coverage will be prospective only, unless you choose to have retroactive coverage to the date of birth in which case you will be required to make premium payments from the date of birth.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Effective Dates of Coverage

Eligible Subscribers:

Your insurance begins on the first of the month following the date we receive and approve your application, enrollment fee and initial premium. Your election continues until December 31, so long as the premium is paid, subject to the Grace Period.

Eligible Dependents:

Your eligible Dependents, as defined, are covered under this Policy:

a) On the date you first become eligible for coverage, if Dependent coverage is provided or elected.

b) On the date you first acquire eligible Dependents, or add Dependent coverage.

c) On the date a new Dependent is acquired if you are already carrying Dependent coverage.

LIMITATION: Dependents of an eligible Subscriber who are in active military service are not eligible for coverage under the Policy.

The eligibility of all Covered Persons, for the purposes of receiving benefits under the Policy, shall, at all times be contingent upon the applicable scheduled payment having been made for such Covered Person.

Family Status Change

Your benefit elections are intended to remain the same for the entire Coverage Year. During the Coverage Year, you will be allowed to change your benefits only if you experience an eligible Family Status Change which includes:

- Change in legal marital status such as marriage or divorce.
- Change in number of Dependents in the event of birth, adoption, placement for adoption or death.
- Change in your or your spouse's employment – either starting or losing a job.
- Change in your or your spouse's work schedule, such as going from full-time to part-time or part- time to full-time, or beginning or ending an unpaid leave of absence.
- Change in Dependent status, such as if a child reaches maximum age under the policy.
- Change in residence or work location so you are no longer eligible for your current health plan.
- Qualification for Medicare or Medicaid.

- Loss of other coverage.

Due to federal regulations, the changes you make to your benefits must be consistent with the Family Status Change event that you experience. For example, if you have a baby, it is consistent to add your newborn to your current dental coverage but it is not consistent to drop your dental coverage altogether.

If a Dependent is no longer eligible under the current policy due to one of the Family Status Changes listed above, they have the right to continue coverage under their own policy and to obtain a policy in their own name. If you need to enroll in your own policy due to a family status change, you may enroll at www.DeltaDentaNE.org or contact Customer Service at the number listed on your ID card for assistance.

If you experience one of the following eligible Family Status Changes during the year, you have 31 days *(except in the case of the birth/adoption of a child - See Effective Dates of Coverage as stated above)* from the event to change your elections. You may obtain a Family Status Change Form by calling Customer Service at 855-663-5677. All changes are effective the date of the change.

Termination of Coverage

Your coverage and that of your Eligible Dependents ceases on the earliest of the following dates:

a) The date you cease to be eligible;

b) For any covered Dependents, the day your Dependent ceases to be a Dependent, as defined in the Eligibility section of this booklet;

c) The last day of the month for which a premium has not been paid, subject to the grace periods; or

d) The date the policy ends.

Renewability

This policy will continue as long as your premiums are paid, subject to the grace period and you continue to be as eligible as determined by Delta Dental.

We reserve the right to terminate the policy, in whole or in part, by giving you written notice at least 31 days advanced notice. Termination of the policy will result in loss of coverage for all covered persons. If the policy is terminated, the rights of the covered persons are limited to covered services incurred before termination. Termination is without prejudice to any claim originating while the policy was in force.

We will only increase the premiums or decrease the benefits provided in this policy effective with a 31 days prior written notice.

PLAN PAYMENTS

Participating Dentist Network

A Delta Dental PPO™ network dentist is a dentist who has signed Delta Dental PPO™ agreement with Delta Dental of Nebraska. The dentist has agreed to accept the Delta Dental PPO™ allowable charge as payment in full for covered dental care. You will be responsible for any applicable deductible and coinsurance amounts

listed in the Summary of Dental Benefits section. A Delta Dental PPO™ dentist has agreed not to bill more than the Delta Dental PPO™ allowable charge. A Delta Dental PPO™ dentist has also agreed to file the claim directly with Delta Dental.

A Delta Dental Premier® dentist is a dentist who has signed a participating and membership agreement with his/her local Delta Dental Plan. The dentist has agreed to accept Delta Dental's Maximum Amount Payable as payment in full for covered dental care. Delta Dental's Maximum Amount Payable is a schedule of fixed dollar maximums established solely by Delta Dental for dental services provided by a licensed dentist who is a participating dentist. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental Premier® dentist has agreed not to bill more than Delta Dental's allowable charge. A Delta Dental Premier® dentist has also agreed to file the claim directly with Delta Dental.

Names of Participating Dentists can be obtained, upon request, by calling Delta Dental, or from Delta Dental's web site at www.DeltaDentalNE.org/myaccount. Refer to the General Information section of this Policy for detailed information on how to locate a participating provider using Delta Dental's website.

Covered Fees

Under this policy, YOU ARE FREE TO GO TO THE DENTIST OF YOUR CHOICE. You may have additional out-of-pocket costs if your dentist is not a Delta Dental Premier® or Delta Dental PPO™ dentist. This payment difference could result in some financial liability to you. The amount is Dependent on the nonparticipating dentist's charges in relation to the Table of Allowances determined by Delta Dental.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN YOUR DELTA DENTAL PREMIER® AND DELTA DENTAL PPO™ NETWORKS PRIOR TO RECEIVING DENTAL CARE.

Claim Payments

PAYMENTS ARE MADE BY DELTA DENTAL ONLY WHEN THE COVERED DENTAL PROCEDURES HAVE BEEN COMPLETED. DELTA DENTAL MAY REQUIRE ADDITIONAL INFORMATION FROM YOU OR YOUR PROVIDER BEFORE A CLAIM CAN BE CONSIDERED COMPLETE AND READY FOR PROCESSING. IN ORDER TO PROPERLY PROCESS A CLAIM, DELTA DENTAL MAY BE REQUIRED TO ADD AN ADMINISTRATIVE POLICY LINE TO THE CLAIM. DUPLICATE CLAIMS PREVIOUSLY PROCESSED WILL BE DENIED. ANY BENEFITS PAYABLE UNDER THIS PLAN ARE NOT ASSIGNABLE BY ANY COVERED PERSON OR ANY ELIGIBLE DEPENDENT OF ANY COVERED PERSON.

Delta Dental Premier® Dentists:

Claim payments are based on Delta Dental's Payment Obligation, which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental Premier® dentist to a Delta Dental covered patient. Delta Dental's Payment Obligation for Delta Dental Premier® dentists is the lesser of: (1) The fee pre-filed by the dentist with their Delta Dental organization; (2) The Maximum Amount Payable as determined by Delta Dental; (3) The fee charged or accepted as payment in full by the Delta Dental Premier® dentist regardless of the amount charged. All Delta Dental Payment Obligations are determined prior to the calculation of any patient co-payments, coinsurances and deductibles as provided under the patient's Delta Dental policy.

Delta Dental PPO™ Dentists:

Claim payments are based on Delta Dental's Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental PPO™ dentist to a Delta Dental covered patient. Delta Dental's Payment Obligation for Delta Dental PPO™ dentists is the lesser of: (1) The fee pre-filed by the dentist with their Delta Dental organization; (2) The Delta Dental PPO™ Maximum Amount Payable as determined by Delta Dental; (3) The fee charged or accepted as payment in full by the Delta Dental PPO™ dentist regardless of the amount charged. All Delta Dental Obligations are determined prior to the calculation of any patient co-payments, coinsurances and deductibles as provided under the patient's Delta Dental policy.

Nonparticipating Dentists:

Claim payments are based on the Delta Dental's Payment Obligation, which for nonparticipating dentists is the treating dentist's submitted charge or the Table of Allowances established solely by Delta Dental, whichever is less. The Table of Allowances is a schedule of fixed dollar maximums established by Delta Dental for services rendered by a licensed dentist who is a nonparticipating dentist. Claim payments are sent directly to the Covered Person.

THE COVERED PERSON IS RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY THE NONPARTICIPATING DENTIST. WHEN SERVICES ARE OBTAINED FROM A NON-PARTICIPATING PROVIDER, ANY BENEFITS PAYABLE UNDER THE CONTRACT ARE PAID DIRECTLY TO THE COVEREDPERSON.

Claim and Grievance Procedures

Initial Claim Determinations

All claims must be submitted within 12 months of the date of service. Upon receipt of a claim, we will respond in writing and provide you, within 15 business days, any necessary forms, instructions and reasonable assistance to enable you to comply with reasonable requirements and any other policy conditions.

Within 15 business days of receipt of claim from you, your authorized representative or the dental provider acting on your behalf if allowed under applicable law, we will initiate an investigation of the claim. We will affirm or deny liability within a reasonable time and pay the claim, or any undisputed portion thereof, within 15 business days of a determination of liability.

Each claim denial or claim payment shall be made in writing and provided to you with an Explanation of Benefits that includes, if applicable, the name of the provider, the services covered, the amount charged, dates of service and a reasonable explanation of the decision, how to submit a Grievance, and the Delta Dental telephone number to call for information and assistance. There will be no penalty for noncompliance with our precertification and/or concurrent review unless the penalty for the same is specifically and clearly set forth in this policy booklet.

We will not withhold any portion of any benefit payable on the basis that the sum withheld is an adjustment or correction of an overpayment made on a prior claim there is documented evidence of such overpayment made on a prior claim and written authorization from the claimant permitting such withholding.

Grievance Procedures

This "Grievance Procedures" section contains important information about Delta Dental's procedures relating to Grievances and requests for Standard and Expedited Reviews, including reviews related to Adverse Benefit Determinations.

You should send your Grievance to the Delta Dental Appeals Unit at the following address:

Delta Dental of Nebraska
Professional Services Appeal and Grievances
PO Box 30416
Lansing, MI 48909

You have the right to contact the Nebraska Department of Insurance if you require assistance at any time at the following address and telephone number:

Nebraska Department of Insurance
1526 K Street, Suite 200
PO Box 95087
Lincoln, NE 68509-5087
Phone: (877) 564-7323
TDD: (800) 833-7352

Definitions

"Adverse Benefit Determination" means a determination by Delta Dental or its designee utilization review agent to deny, reduce or terminate a dental benefit, or a failure to provide or make payment (in whole or in part) of a dental benefit.

"Grievance" means a written complaint submitted by a Covered Person or a Covered Person's authorized representative or dental provider if allowed under applicable law, regarding: (a) the availability, delivery, or quality of dental care services, including a complaint regarding an Adverse Benefit Determination; (b) claims payment, handling, or reimbursement for dental care services; or (c) matters pertaining to the contractual relationship between a Covered Person and Delta Dental.

"Expedited Review" means a review of a Grievance for which the time requirements for Standard Review, if followed, could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function.

"Standard Review" means the requirement of Delta Dental to conduct a review and respond to a non-urgent Grievance of a Covered Person within 15 business days from receipt of the Grievance.

Upon request and free of charge, you are entitled to receive reasonable access to and copies of all records relevant to your Grievance, including evidence or documentation used by Delta Dental in its determination, including, for Adverse Benefit Determinations, the clinical rationale and review criteria used in making the determination.

Grievance: Standard Review

You may file a Grievance under Standard Review on any relevant matter within 180 days of your receipt of the Explanation of Benefits provided to you.
Delta Dental will provide you a written notice of our receipt of your Grievance within 3 business days. The notice will provide you with the name, phone number and address of the person to contact who will be coordinating the review. You, or your authorized representative, do not have the right to attend the review, but you may submit written comments, documents, or other information in support of your Grievance.

The review will take into account all information regarding the claim (whether or not presented or available at the initial determination) and the initial determination will not be given any weight.

Delta Dental will respond in writing with our decision to your Grievance within 15 business days. If, however, Delta Dental cannot make a determination within 15 business days due to circumstances beyond our control, except in the case of an Adverse Benefit Determination, we may take up to an additional 15 business days to make the determination. If this is necessary, Delta Dental will provide you with written notice on or before the 15th business day after receiving your Grievance.

Special Provisions Relating to Standard Review of Adverse Benefit Determination

In addition to the above "Grievance: Standard Review" provisions, when reasonably necessary or when requested by the dental provider acting on behalf of the Covered Person, Standard Reviews of Adverse Benefit Determinations will be evaluated by an appropriate clinical peer. The clinical peer will not have been involved in the initial Adverse Benefit Determination. If the Standard Review of an Adverse Benefit Determination does not resolve the matter, you, your authorized representative or dental provider if allowed under applicable law, may submit another Grievance to Delta Dental.

Grievance: Expedited Review

If your Grievance involves a matter that requires Expedited Review, you, or your authorized representative or the dental provider acting on your behalf, may request an review of your Grievance either in writing or orally. All necessary information, including Delta Dental's decision, will be submitted by the most expeditious method available. Delta Dental will make a decision and notify you, or your authorized representative or the dental provider acting on your behalf, no more than 72 hours after the request for Expedited Review is received. Delta Dental will provide written confirmation of our decision within 2 business days after providing initial notification of our decision, if the initial notification of our decision was not in writing.

Expedited Review of Grievances that result in an Adverse Benefit Determination will be evaluated by an appropriate clinical peer. The clinical peer will not have been involved in the initial Adverse Benefit Determination. Delta Dental will provide reasonable access to the clinical peer within 1 business day after receipt of the request for Expedited Review of the Grievance.

If your request for Expedited Review is a concurrent care review determination, your coverage will continue for the dental care service until Delta Dental notifies you of its decision.

If the Expedited Review does not resolve the matter, you, your authorized representative or dental provider if allowed under applicable law, may submit another Grievance to Delta Dental.

Note: Delta Dental is not required to provide an Expedited Review for retrospective Adverse Benefit Determinations.

Written Decision

When a decision is issued by Delta Dental in a response to a Grievance, including a Grievance related to an Adverse Benefit Determination, submitted for either Standard Review or Expedited Review, Delta Dental's written notice to you shall contain: (a) the names, titles and credentials of the person or persons reviewing the Grievance; (b) a statement of the reviewer's understanding of the Grievance; (c) the decision and the basis for such decision in sufficient detail to allow you to make further responses to Delta Dental's position; (d) evidence or documentation used in making the decision; (e) in cases of Grievances involving Adverse Benefit Determinations, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the decision; and (f) notice of your right to contact the Nebraska Department of Insurance, along with the telephone number and address.

Authorized Representative
You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or a Grievance as described above. However, no authorization is required for your treating dentist to make a claim or appeal on your behalf, unless required under applicable law. The authorization form must be in writing, signed by you, and include all the information required in our Authorized Representative form. The Authorized Representative form is available at our website at www.DeltaDentalNE.org/myaccount or by calling Customer Service at 855-663-5677. You can revoke the authorized representative at any time.

GENERAL INFORMATION

Health Plan Issuer Involvement

Delta Dental is the health plan issuer involved with the policy. Its address is stated on the back cover of this Policy. The benefits under the policy are guaranteed by Delta Dental under the Contract. Delta Dental will review claims incurred and submitted for enrollees under prior coverage with Delta Dental in determining benefits under this coverage.

Delta Dental of Nebraska has the sole authority, discretion and responsibility to interpret and apply the terms of this policy and to determine all factual and legal questions under the policy, including the amount of benefits to be paid under the insurance policy, if any.

Privacy Notice

Delta Dental of Nebraska will not disclose non-public personal financial or health information concerning persons covered under out dental benefit plans to non-affiliated third parties except as permitted by law or required to adjudicate claims submitted for dental services provided to persons covered under our dental benefit plans.

How to Find a Participating Dentist

A real-time listing of participating dentists is available in an interactive directory at Delta Dental's user

friendly web site, www.DeltaDentalNE.org. Delta Dental highly recommends use of the web site for the most accurate network information. Visit DeltaDentalNE.org/find-a-dentist and enter your ZIP code, city or state to find local participating dentists. You can also search by dentist or clinic name. The web site also allows you to print out a map directing you to your selected dental office. **The Dentist Search is an accurate and up-to-date way to obtain information on participating dentists.**

To search for and verify the status of participating providers, select "Find a Dentist" on the www.DeltaDentalNE.org home page. Select the Product or Network in the drop-down menu, and search by city and state, ZIP code or provider or clinic name. If your dentist does not participate in the network, you may continue to use that dentist, although you will share more of the cost of your care and could be responsible for dental charges up to the dentist's full billed amount.

If you do not have Internet access, you can also find a network dentist or verify that your current dentist is in the network by:

- Asking the dental office representative when you call to schedule a dentist appointment.
- Contacting our Customer Service Center at (855) 663-5677. Customer Service hours are 7 a.m. - 7 p.m. CT, Monday through Friday.

Using Your Dental Benefits

Dentists who participate with Delta Dental are independent contractors. The relationship between you and the participating dentist you select to provide your dental services is strictly that of provider and patient. Delta Dental cannot and does not make any representations as to the quality of treatment outcomes of individual dentists, nor recommends that a particular dentist be consulted for professional care.

All claims should be submitted within 12 months of the date of service.

If your dentist is nonparticipating, claim forms are available by calling (855) 663-5677 or by logging on to our website at www.DeltaDentalNE.org.

Delta Dental also accepts the standard American Dental Association (ADA) claim form used by most dentists.

If your dentist is a participating dentist , the dental office will file the claim form with Delta Dental; however, you may be required to assist in completing the patient information portion on the form (Items 1 through 14).

During your first dental appointment, it is very important to advise your dentist of the following information:

* YOUR DELTA DENTAL GROUP NUMBER
* YOUR IDENTIFICATION NUMBER (your Dependents must use **YOUR** identification number)
* YOUR BIRTHDAY AND THE BIRTH DATES OF YOUR SPOUSE AND DEPENDENT CHILDREN

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Delta Dental of Nebraska is required by law to maintain the privacy of your Protected Health Information, to provide you with this notice of its legal duties and privacy practices with respect to your Protected Health Information, and to notify you following a breach of unsecured Protected Health Information. This notice is being issued to comply with the requirements of the Privacy Rules under the Health Insurance Portability and Accountability Act (HIPAA Privacy Rules). Individually identifiable information about your past, present or future health or condition, the provision of health care to you, or payment for such health care is considered "Protected Health Information" (PHI).
Health care includes dental care.

Our Permitted Uses and Disclosures of Your Protected Health Information

We use and disclose PHI about you without your authorization for treatment, payment, and health care operations.

Treatment: We may disclose PHI to your dentist(s) for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seek information from us as to whether the service has been previously provided.

Payment: We use and disclose your PHI in order to fulfill our duty to provide your coverage, determine your benefits, and make payment for services provided to you. For example, we may use and disclose your PHI in order to process your claims.

Health Care Operations: We use and disclose your PHI as a part of certain operations, such as quality improvement. For example, we may use and disclose your PHI to evaluate the quality of dental services that were performed or to check for fraud and abuse.

We may not, however, use or disclose any PHI that is considered genetic information under Federal Law for underwriting purposes.

Unless you object, we may disclose your PHI to a family member, other relative, person authorized by law, or any other person you identify as involved in your care or the payment related to your care. Only PHI relevant to that person's involvement in your care or the payment related to your care will be disclosed. You can restrict this disclosure at any time, subject to certain limitations. If you are incapacitated or in the event of an emergency, we will exercise professional judgment to determine whether a disclosure of this type is in your best interest.

We may also use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may us or disclose your PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We may disclose PHI in response to a court or administrative order, subpoena, discovery request or other lawful process if certain conditions are met and the required assurances are received. We provide PHI when otherwise required by law, such as for law enforcement purposes. We may disclose your PHI to public health or other appropriate authorities to lessen a serious or imminent threat to the health or safety of you or the public. In any other situations not described here, we will ask for your written authorization before using or disclosing your PHI. If you choose to sign an

authorization to allow disclosure of your PHI, you can later revoke that authorization to stop any future uses and disclosures (other than for treatment, payment and health care operations).

We reserve the right to change this notice at any time and for any reason. We reserve the right to make the revised or changed notice effective for PHI we currently maintain as well as any information received in the future. A copy of our most current notice will be posted at www.DeltaDentalNE.org.

Individual Rights

In most cases, you have the right to view or get a copy of your PHI which is held in a particular record set by us. You may request copies for a nominal per-page charge. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your PHI for treatment, payment and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations, if you clearly state that disclosure of all or part of your PHI could endanger you. You also have the right to receive notice following an unauthorized access, use or disclosure of your PHI if that unauthorized access, use or disclosure is considered a "breach" as defined by the HIPAA Privacy Rules.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, request a paper copy of this Notice or if you have any questions, complaints or concerns, please contact:

Customer Service
PO Box 1886
Indianapolis, IN 46206-1886
(855) 663-5677

DELTA DENTAL OF NEBRASKA

FOR CLAIMS AND ELIGIBILITY
Customer Service
PO Box 1886
Indianapolis, IN 46206-1886
(855) 663-5677

DELTA DENTAL OF NEBRASKA
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Suite 300
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