WEBT

Dental Benefit Booklet

Standard Option

Effective July 1, 2025

Claims Administrator:

DELTA DENTAL®

INTRODUCTION

This document describes the Dental Plan maintained for the exclusive benefit of the members of the Wyoming Educators' Benefit Trust (WEBT). The Group intends to maintain this Plan indefinitely but reserves the right to terminate in accordance with the WEBT Participation Agreement. Changes in the Plan may be made in any or all parts of the Plan including, but not limited to, services covered, Deductibles, Copayments, Maximums, Exclusions or Limitations, Definitions, Eligibility, etc.

Benefits under the Plan will only be paid for expenses incurred while the coverage is in force. Benefits will not be provided for services incurred before coverage under the Plan began or after coverage under the Plan is terminated. An expense is considered to be incurred on the date the service or supply was provided.

Delta Dental of Wyoming (Delta Dental) provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

THIS IS A LIMITED BENEFIT DENTAL POLICY. THIS POLICY PROVIDES DENTAL BENEFITS ONLY. PLEASE READ THIS POLICY CAREFULLY.

THIS POLICY DOES NOT PROVIDE FOR ADULT WELLNESS BENEFITS AS DEFINED BY W.S. 26-18-103(B).

TO OBTAIN INFORMATION OR MAKE A COMPLAINT, PLEASE CONTACT WEBT AT (307) 634-5566 OR DELTA DENTAL AT 1-800-735-3379.

DELTA DENTAL

WEBT

WEBT – Standard Option Plan
July 1, 2025

Benefits	PPO + Premier Network
Maximum Benefit (per eligible person, age 19 and over)	$1,200.00
Maximum Benefit (per dependent child to age 19) Not subject to any lifetime or calendar year maximums. These services are still subject to the deductible.	Unlimited
Orthodontic Maximum (per unmarried dependent child to age 19)	$1,500.00 lifetime
Orthodontic Maximum (medically necessary orthodontia) Not subject to any lifetime or calendar year maximums or deductibles. Must meet specific medically necessary requirements.	Unlimited
Deductible √ Deductible does NOT apply to Diagnostic and Preventive or Orthodontic Services.	$50 per person $100 per family
Services	
Diagnostic & Preventive Services √ Routine periodic examinations, including bitewing x-rays twice per calendar year. √ Dental prophylaxis (cleaning) twice per calendar year. OR √ Periodontal maintenance not more than two per calendar year. ○ **Benefit is for either a prophylaxis/cleaning or periodontal maintenance, subscribers cannot utilize both.** √ Topical fluoride applications once every twelve months. (Dependents to the end of the month age 19 is attained.) √ Space maintainers, fixed. (Dependents to the end of the month age 19 is attained.) √ Sealants. (Dependents to the end of the month age 19 is attained.) √ Full mouth x-rays once every three years.	100%
Basic Services √ Extractions and other oral surgery. √ Amalgam, preformed crowns, synthetic porcelain, plastic, and composite restorations (fillings.) √ Root canals. √ Periodontics.	80%
Major Services √ Crowns when teeth cannot be restored with a filling material. √ Prosthetics - provides bridges, partial dentures, and complete dentures. √ Dental implants. √ Inlays & Onlays	50%
Orthodontic Services √ Limited to covered, unmarried children under the age of 19	50%

Additional Info:

- √ Visit our website at www.deltadentalwy.org or download the free Delta Dental app for iPhone or Android to see your benefits, your Explanation of Benefits or to find a dentist!
- √ You will receive two ID cards in your enrollment packet. If you need additional copies, please request one via the website or by calling our office at 800-735-3379.
- √ Verify your coverage. Login to your secure subscriber account on our website or our free mobile app to see your benefits and eligibility. If you think you may need treatment in excess of $250, ask your dentist to submit a predetermination. That way you'll understand your full financial responsibility upfront.
- √ Your oral health is very closely related to your overall health. Preventive dental visits are an important way to maintain not just a healthy mouth but a healthy body as well.

Delta Dental of Wyoming
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Definitions

Alternate Benefit is a provision in a dental plan contract that allows the third-party payer to determine the benefit based on an alternative procedure that is generally less expensive than the one provided or proposed.

Annual Maximum Benefit is the maximum benefit each member is eligible to receive for certain covered services in a coverage year. The annual maximum benefit is reached from claims settled under this handbook in a coverage year. This amount is shown on the Benefit Overview sheet. Refer to the Benefit Overview sheet to see lifetime benefit for orthodontics (braces).

Approved Amount is the total amount that the dentist is permitted to collect as payment in full for the specified service. It includes the dental benefit plan's payment as well as the patient's deductible and/or co-insurance.

Benefits are services covered under a dental plan.

Billed Charge is the amount a dentist bills for a specific dental procedure.

COBRA or Consolidated Omnibus Budget Reconciliation Act is a law that requires certain employers to offer continued health coverage to eligible employees and/or their dependents who have had their health/dental coverage terminated.

Co-insurance/Cost Sharing is the percentage of dental expenses you pay after the deductible is met, until you reach your annual maximum benefit.

Completion Date is the date a procedure is completed. It is the insertion date for dentures and partial dentures. It is the cementation date (regardless of the type of cement used) for inlays, onlays, crowns, and fixed bridges.

Contract means this agreement between WEBT and the Group. This Contract constitutes the entire Contract between the parties.

Contract Year means period commencing on the Effective Date and each twelve (12) month renewal period thereafter.

Coverage Percentage means the percentage of the maximum plan allowance paid by Delta Dental for a specific benefit, as specified on the Benefit Overview.

Coverage Year means the 12-month period over which a group's deductibles, maximums and other provisions apply. Also known as the calendar year.

Deductible is the dollar amount you pay for covered services in a coverage year before benefits are available under this handbook. This amount is shown on the Benefit Overview sheet in the front of this handbook. The family deductible is reached from deductible amounts paid on behalf of any combination of members.

Delta Dental means Delta Dental Plan of Wyoming, a non-profit dental service corporation, d.b.a. Delta Dental of Wyoming, acting for itself.

Dependents are the following persons, who are eligible for coverage under this Plan, and for which the Subscriber has elected coverage under this Plan:

1. Spouse - A person (of the same or opposite sex of the Subscriber) to whom a person is legally married to under the laws of the state or nation that were in place at the time and in the location that the marriage was entered into, and who is currently a permanent resident in the home of the Subscriber.

2. Civil Partner - A person (of the same or opposite sex of the Subscriber) with whom the Subscriber has entered into a civil union in a state or nation that sanctions such unions by law, and that is valid pursuant to such law at the time that the parties entered into the relationship, and who is currently a permanent resident in the home of the Subscriber. Civil Partners are eligible for coverage only if specifically permitted by the Group's policy.

3. Child/Children - The child or children, including newborn children, stepchildren, adopted children, children which the court has decreed support to the Subscriber or the Subscriber's covered Spouse or Civil Partner and legal wards of the Subscriber or the Subscriber's covered Spouse or Civil Partner. The limiting age for covered Children is the end of the month in which age 26 is attained *unless otherwise* established by the Group.

   Eligibility will be continued past the limiting age for unmarried children who are BOTH incapable of self-sustaining employment and chiefly dependent upon the Subscriber, or the Subscriber's covered Spouse or Civil Partner for their support and maintenance by reason of mental or physical disability. Continuous coverage will be established at the same level of benefits. Proof of incapacity and dependency must be furnished to the Group within thirty-one (31) days of the end of the month in which the limiting age is attained. Incapacity and dependency upon the Subscriber, or the Subscriber's covered Spouse or Civil Partner, must both continue for the coverage to continue. Proof of such incapacity and dependency may be required from time to time. If the conditions of BOTH incapacity and dependency by reason of mental or physical disability are not continuously met, coverage will continue as required by Federal or State law as applicable.

4. Eligible Employee means any employee who meets the conditions of eligibility outlined by the Group.

Eligibility Date means the date an employee's eligibility for benefits becomes effective under the terms of this Contract.

Exclusion is a dental service or procedure not covered by a dental program.

Explanation of Benefits is a statement sheet that explains how your claim was processed, payment by Delta Dental, your responsibility, and other pertinent information.

Grievance means any dissatisfaction with the administration, claims practices or provision of services by Delta Dental that is expressed in writing by or on behalf of an eligible person.

Group means the employer, contracting with WEBT to provide benefits to its eligible employees or members and/or their dependents if applicable.

Health Insurance Portability and Accountability Act of 1996 is a federal law that requires all health plans, including health care clearinghouses and any dentist who transmits health information in an electronic transaction, to use a standard format. Providers' paper transactions are not subject to this requirement.

ID number is the unique number assigned by Delta Dental.

Initial Enrollment Period means the initial period, as determined by the group and WEBT during which eligible employees may enroll eligible persons.

Late Enrollee is a subscriber or dependent that does not enroll in the plan when initially eligible.

Limitations are restricting conditions - such as age, period of time covered - under which a group or individual is covered.

Lifetime Maximum on Orthodontia is the amount your plan will pay during your lifetime (or your dependents lifetime) while covered under this plan for a non-medically necessary orthodontics.

Medical Necessity/Dental Necessity means (effective July 1, 2010 Wyoming Statue 26-40-102) A medical/dental service, procedure or supply provided for the purpose of preventing, diagnosing or treating an illness, injury, disease or symptom.

- Is medically/dentally appropriate for the symptoms, diagnosis or treatment of the condition, illness, disease or injury; Provides for the diagnosis, direct care and treatment of the patient's condition, illness, disease or injury;

- Is in accordance with professional, evidence-based medicine and recognized standards of good medical/dental practice and care; and

- Is not primarily for the convenience of the patient, doctor/dentist or other medical/dental provider.

A medical/dental service, procedure or supply shall not be excluded from being a medical/dental necessity under this section solely because the service, procedure or supply is not in common use if the safety and effectiveness of the service, procedure or supply is supported by:

- Peer reviewed medical/dental literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE); or

- Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act.

Non-participating Dentist is a state-licensed dentist who does not have a written participation agreement with Delta Dental.

Open Enrollment Period means an enrollment period after the initial enrollment period during which eligible persons may apply to become covered persons. An open enrollment period will be offered annually during the month of November for an effective date of the following January 1.

Optional Treatment Delta Dental will pay the pre-approved fee for the least expensive dental procedure that is equally effective. You will be responsible for the remainder of the dentist's fee if a more expensive dental procedure is selected.

Participating Dentist is a licensed dentist who has signed a Delta Dental service agreement. Delta Dental's payment and the patient's payment, if any, are to be accepted by the contracting dentist as payment in full. Delta Dental's payment is sent directly to the contracting dentist. To find a participating dentist go to www.deltadentalwy.org. Click on "Find a Dentist". Then select "Delta Dental PPO Plus Premier" and enter your city or zip code.

Predetermination is the process by which Delta Dental determines if a procedure or treatment is a referable Benefit under the Enrollee's plan prior to the procedure being completed.

Premium means amounts payable monthly by Group.

Primary Insurance is the insurance carrier or third-party payee that pays for services rendered to a covered person before any other carriers would.

Secondary Insurance is the insurance carrier or third-party payee that would process its payment for a claim after a primary carrier made payment and make any additional payments as necessary.

Single Procedure means a dental procedure to which a separate procedure number has been assigned. (See Article X Procedure Codes and Nomenclature of this Contract.)

Special Enrollment Period means the 30-day period of time after each of the following events (61 days for birth or adoption) during which an eligible employee can enroll eligible persons under this contract:

a. A change in family status (marriage, divorce, legal separation, birth of a natural born child, or adoption of a child) after the effective date of the policy;

b. A loss of other coverage under another group plan;

c. COBRA exhaustion;

d. Loss of coverage under the eligible employee's alternate plan

e. Termination of Medicaid coverage or the Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (allows for a 60-day period of time to elect coverage);

Subscriber means an eligible employee or member of the group who (a) has completed and signed the documents necessary for coverage under the contract, (b) has been accepted by WEBT as a subscriber, and (c) for whom the appropriate premium has been paid.

Benefit Overview is a listing of the specific benefits and benefit limitations for dental services provided under the terms of your group's contract.

Treatment Plan is a written report prepared by a dentist showing the dentist's recommended treatment of any dental disease, defect, or injury.

Participating Dentists

Participating dentists signed an agreement with Delta Dental and agree to abide by certain guidelines, such as not charging Delta Dental subscribers more than the pre-approved fees. This may result in savings. When you receive services from dentists who participate with Delta Dental of Wyoming or any other Delta Dental, all the following statements apply:

- Participating dentists agree to file claims for you.
- Participating dentists do not charge the patient up front for any amount covered by Delta Dental except deductible and co-payment.
- Participating dentists will not charge back to the patient (balance bill) any amount over the amount allowable by Delta Dental.
- Claims are paid directly to participating dentists. You are responsible to pay your dentist for any deductible, coinsurance, or non-approved charge.
- It is HIGHLY recommended that participating dentists file a Predetermination of Benefits when you have a treatment plan exceeding $250. This will assist you and the dental office in knowing if a treatment plan will be covered prior to it being completed.

Non-Participating Dentists

When you receive services from non-participating dentists, you will not receive any of the advantages that our agreement offers. As a result, when you receive services from non-participating dentists, all the following statements apply:

- Non-participating dentists do not accept Delta Dental's pre-approved fees. This means you are responsible for any difference between their charge and what Delta Dental pays.
- Non-participating dentists are not responsible for filing your claims.
- Claims are paid to you. You are responsible for paying your dentist for claims as well as any deductible, coinsurance, or non-approved charge.
- Non-participating dentists do not agree to file Predetermination of Benefits for you.

Delta Dental's Payment on Claims

Our policy is to send our payment for treatment after it is completed – not before. For example, we will send payment when:

- A crown is placed, not when it is cut.
- A fixed or removable prosthesis is placed.
- A root canal is filled.

Maximum Plan Allowance (MPA)

The maximum plan allowance is the amount that Delta Dental will pay for a service, supply, or dental procedure. The maximum plan allowance is established by Delta Dental of Wyoming and is developed from various sources, such as agreements with dentists, input from dental consultants, the simplicity or complexity of the procedure, and the charges for procedures by dentists in Wyoming.

For services billed by dentists outside of Wyoming, the maximum plan allowance is based on information from that state's Delta Dental.

Payment Procedures

Delta Dental shall pay the following benefits upon the participating dentist's usual, customary and reasonable fee. The fee paid for any covered service shall be the lesser: a) the fee submitted on the Attending Dentist's Statement (claim form); or b) the maximum plan allowance, as determined by Delta Dental of Wyoming.

The amounts payable by Delta Dental with respect to the services rendered by a Non-Participating Dentist shall not exceed the dentist's fees, or the non-participating maximum plan allowance, whichever shall be less.

The amounts payable by Delta Dental with respect to services rendered by a dentist in another state or country who is not a Participating Dentist of Delta Dental in that state shall not exceed the amount that would be payable if such services had been provided by a Participating Dentist in Wyoming.

The amounts payable by Delta Dental with respect to services rendered by a dentist in another state who is a Participating Dentist of a Delta Dental Plan in that state shall be those that would be payable by that other Delta Dental Plan.

Coverage after Termination

If an Individual's coverage terminates while he/she is receiving treatment under a predetermination of benefits which was approved while he/she was eligible for benefits, benefits will not continue to be paid for such approved treatment.

Coverage Period

An Eligible Subscriber/Dependent becomes covered on the effective date established by the Group's eligibility policy or in accordance with the open enrollment period.

Benefits

Class I – Diagnostic and Preventive Services

Pediatric Services
Preventive and Diagnostic, Restorative Procedures and Prosthodontic Treatment
Preventive and diagnostic, restorative procedures and prosthodontic treatment are available to dependents until the end of the month in which they turn 19 and are not subject to any lifetime or

calendar maximums. These services will still be subject to the dental deductible and the specified payment of the allowable charges as stated above. Pediatric services will apply to the total in-network out-of-pocket maximum amount.

Dental Cleaning (Prophylaxis) - Removing plaque, tartar (calculus), and stain from teeth.
Limitation: Dental cleaning is a benefit twice per calendar year.

OR

Periodontal Maintenance Therapy - Includes various maintenance services such as pocket depth measurement, dental cleaning (oral prophylaxis), removal of stain and root planing and scaling.
Limitation: This procedure must follow conservative or complex periodontal therapy and is allowed no more than twice per calendar year. This procedure replaces the dental cleaning benefit (prophylaxis) described above.

Oral Evaluations (Exams)
Limitation: Dental examinations are a benefit twice per calendar year.

Fluoride Applications
Limitation: Fluoride applications are a benefit only when applied by dental professionals. Fluoride applications are a benefit only once every twelve months for dependent children under age 19.

X-Rays (Radiographs)
Limitation: Cone beam imaging, MRI's, and ultrasound procedures are not a covered benefit.

Bitewing X-Rays
Limitation: Bitewing x-rays are a benefit twice per calendar year.

Full Mouth/Panoramic X-Rays - Full mouth x-rays are a combination of individual x-rays such as periapicals, bitewings or occlusal films taken by a dentist on the same service date.
Limitation: Full-mouth or panoramic x-rays are a benefit once every 36 consecutive months.

Occlusal X-Rays
Limitation: These x-rays are a benefit twice in a 24-month period.

Periapical X-Rays
Limitation: These x-rays are a benefit on an as needed basis determined by your dentist, not to exceed benefits/limitations outlined as full mouth x-rays.

Sealant Applications - Filling decay-prone areas of the chewing surface of molars.
Limitation: Sealant applications are a benefit once every three years for unrestored 1st and 2nd permanent molars for eligible dependent children under age 19. Sealants for primary teeth, wisdom teeth, or teeth that have already been treated with a filling/restoration are not a benefit.

Space Maintainers for Missing Primary Back Teeth
Limitation: Space maintainers are a benefit only for eligible dependent children under age 19.

Emergency Treatment (Palliative Treatment) - Emergency treatment for temporary relief of dental pain or infection.

Class II – Basic Services

Procedures in this category should receive our review before they are performed. See Predetermination of Benefits.

Prefabricated Crowns - Pre-fabricated or stainless-steel restorations.
Limitation: These benefits are covered once in a 24-month period. Restorations for the primary purpose of cosmetics or restoring a tooth due to attrition, abrasion, erosion, and abfractions are not a benefit.

Routine Restoration of Decayed or Fractured Teeth - Restoring the tooth with silver (amalgam) fillings, tooth colored (composite/resin) fillings.
Limitation: These benefits are covered once per surface in a 24-month period. Restorations for the primary purpose of cosmetics or restoring a tooth due to attrition, abrasion, erosion, and abfractions are not a benefit.

Routine Extractions - Routine removal of tooth structure, minor smoothing of socket bone and closure as necessary.

General Anesthesia/Sedation
Limitation: General anesthesia and intravenous sedation are benefits only when provided in conjunction with surgical extractions and other covered surgical procedures and when billed by the treating dentist. Simple/routine extractions, even when provided by an oral surgeon do not qualify for sedation coverage.

Oral Surgery - Including surgical removal of teeth, and other surgical services to the teeth or immediate surrounding hard and soft tissues that are being performed due to disease, pathology, or dysfunction of dental origin.
Limitation: Some types of oral surgery may not be a benefit.

Pulpotomy - Removing the coronal portion of the pulp as part of root canal therapy. When performed on a baby (primary) tooth, pulpotomy is the only procedure required for root canal therapy.

Apicoectomy/Periradicular Surgery - Surgery to repair a damaged root as part of root canal therapy or to correct a previous root canal.

Retrograde Fillings - Sealing the root canal by preparing and filling it from the root end of the tooth.

Root Canal Therapy - Treating an infected or injured pulp to retain tooth function. This procedure generally involves removal of the pulp and replacement with an inert filling material.
Limitation: If retreatment is required, it is a benefit following 24 months from the completion of the original root canal and limited to one retreatment per tooth.

Full Mouth Debridement (Difficult Cleaning)
Limitation: Benefit is once per lifetime.

Conservative Periodontal Procedures - (Root Planing and Scaling) Removing contaminants such as bacterial plaque and tartar (calculus) from a tooth root to prevent or treat disease of the gum tissues and bone which support it.

Limitation: Conservative periodontal procedures are a benefit only once every 24 consecutive months for each quadrant of the mouth.

Complex Periodontal Procedures - Various surgical interventions designed to repair and regenerate gum and bone tissues that support the teeth.
Limitation: Complex periodontal procedures are a benefit once in 36 months/3 years for each quadrant of the mouth for natural teeth only. A quadrant is one of the four equal sections of the mouth into which the jaws can be divided.

Class III – Major Services

Procedures in this category should receive our review before they are performed. See Predetermination of Benefits.

Major Restorations for Complicated Tooth Decay or Fracture - Restoring a tooth with a cast filling (including local anesthesia) when the tooth cannot be restored with a silver (amalgam) or tooth colored (composite) filling. An x-ray must accompany all claims for crowns.
Limitation: Procedures in this category are available once every 5 years beginning from the date the major restoration is cemented in place. This includes teeth crowned and then extracted within the five-year period and replaced with a bridge or implant crown. Procedures in this category are not a program benefit under age 16.

Crowns - Restoring form and function by covering and replacing the visible part of the tooth with a precious metal, porcelain-fused-to-metal, or porcelain crown. Crowns are a benefit only if the tooth cannot be restored with a routine filling.
Limitation: Crowns placed for the primary purpose of periodontal splinting, cosmetics, altering vertical dimension, restoring your bite (occlusion), allergies, or restoring a tooth due to attrition, abrasion, erosion, and abfractions are not a benefit. Crowns are a benefit following root canal treatment only when significant amount of tooth structure is missing due to decay and/or fracture and cannot be restored with a routine filling. If sufficient tooth structure remains, benefits are not allowed.

Crown replacement due to porcelain fracture is not a benefit. An x-ray must accompany all claims for crowns.

Inlays Restorations - Restoring a tooth with a cast metal or porcelain filling.
Limitation: Inlays are limited to the amount paid for a silver (amalgam) filling. If a tooth colored material is used to restore back (posterior) teeth, benefits are limited to the amount paid for a silver filling. You are responsible for paying the difference. These benefits are covered once per surface in a 5-year period. Inlay restorations for the primary purpose of cosmetics or restoring a tooth due to attrition, abrasion, erosion, and abfractions are not a benefit. Inlays are a benefit.

Onlays Restorations - Replacing one or more missing or damaged biting cusps of a tooth with a cast restoration. The same criteria for crown coverage applies to onlays.

Posts and Cores - Preparing a tooth for a cast restoration after a root canal when there is insufficient strength and retention.

Recementation of Major Restorations
Limitation: Benefits are limited to once per lifetime.

Prosthetics are fixed bridgework, partial and complete dentures, and implants used to replace missing permanent teeth. Bridges and dentures (partial or complete) are a benefit once every 5 years from the date they are placed and then only if the existing prosthetic is unserviceable whether Delta Dental paid for the original dental procedure under this plan. Fixed bridges and partial/complete dentures or implants are provided when chewing function is impaired due to missing teeth. Procedures in this category are not a program benefit under the age of 16.

Bridges - Replacing missing permanent teeth with a dental prosthesis that is cemented in place and can only be removed by a dentist. Bridge repairs are also covered.
Limitation: Bridges which are supported by dental implants are limited to the amount paid for a bridge supported by natural teeth. All ceramic bridges are only a benefit for upper or lower anterior teeth. An alternate benefit of porcelain fused to metal will be made for all ceramic posterior bridges.

Dentures (Complete and Partial) - Replacing missing permanent teeth with a dental prosthesis that is removable. Denture repair and relining are also covered.
Limitation: Dentures which are supported by surgically placed dental implants will be limited to the amount paid for a conventional complete denture.

Denture Adjustments
Limitation: Denture adjustments are limited to two per denture per coverage year after 6 months has elapsed since initial placement.

Denture (Complete and Partial) Relines
Limitation: Denture relines will be limited to twice in a 5-year period.

Denture (Complete and Partial) Rebase
Limitation: Dentures and/or denture rebase will be limited to twice in a 5-year period.

Implants - Coverage is provided when chewing function is impaired due to missing teeth and could include surgical placement or removal of implants or attachments to implant.
Limitations: Predetermination is recommended. Delta Dental does not cover the maintenance or the surgical removal thereof.

Tissue Conditioning
Limitation: Tissue conditioning is limited to two per denture every 24 consecutive months.

Class IV Services – Orthodontics

Orthodontic Treatment: The following Orthodontic Treatment that is not Medically Necessary is limited to 50% of allowable charges, subscriber is responsible to provide payment for the remaining 50% of Allowable Charges. Orthodontic Treatment is limited to a lifetime maximum as specific on the Benefit Overview and is available only to covered, unmarried dependent children until the end of the month in which they turn age nineteen (19).

Work in progress and take over orthodontia is when you are an existing employee and your employer changes to a Delta Dental plan that includes orthodontic coverage or you are a new employee who did not have prior orthodontic benefits or had orthodontic benefits through your prior employment. In a work in progress or take over situation, your treatment will have begun prior to your Delta Dental effective date. Delta Dental will begin paying benefits for eligible treatment upon your effective date (unless your plan has a waiting period associated with orthodontic benefits) up to the lifetime maximum for the remaining months of treatment. Delta Dental's lifetime

maximum for orthodontics would be reduced by any amounts paid by a prior carrier, including circumstances where your prior carrier was Delta Dental.

Orthodontic Services/Braces Orthodontics are services for the proper alignment of teeth.

Diagnostic Cast
Limitation: Diagnostic cast is a benefit only in conjunction with orthodontic treatment.

Medically Necessary Orthodontic Treatment:
Orthodontic Treatment that is Medically Necessary is available only to covered, unmarried dependent children until the end of the month in which they turn 19. Medically Necessary Orthodontic Treatment is limited to 50% of the Allowable Charges and the Participant is responsible to provide payment for the remaining 50% of the Allowable Charges. Medically Necessary Orthodontic Treatment is not subject to any lifetime or calendar year maximums.

Medically necessary orthodontia must be approved by Delta Dental prior to treatment. For questions, please contact our office at 1-800-735-3379.

Services not Covered

The limitations and exclusions listed in this policy apply to all covered services described in this benefit document. Benefits will not be provided for any service not specifically listed as a covered service or will be limited as indicated. Call us at 1-800-735-3379 if you are unsure if a certain service is covered.

Exclusions - *This handbook does not provide benefits for dental treatment listed in this section.*

Absence of coverage
Dental procedures, services, treatment and supplies for which the Covered Person would have no obligation to pay in the absence of this or any similar coverage.

Allergies
You are not covered for restorations or procedures necessary due to allergies or allergic reaction to dental treatment materials such as allergies to metals or mercury.

Anesthesia or analgesia
You are not covered for local anesthesia or nitrous oxide (relative analgesia) when billed separately from the related procedure. This exclusion does not apply to general anesthesia or intravenous sedation administered in connection with covered oral surgery as described in the benefits section of this policy.

Broken appointments
You are not covered for any fees charged by your dental office because of broken appointments.

Cleaning of prosthetic appliance
Your plan does not cover the cost of cleaning removable partials or dentures.

Charges for consultation
Charges for consultation are not a covered benefit.

Completion of form
Your plan does not cover any charges to complete forms.

Complete occlusal adjustment
You are not covered for services or supplies used for revision or alteration of the functional relationships between upper and lower teeth.
Complications of a non-covered procedure
You are not covered for complications of a non-covered procedure.

Comprehensive Services
When two or more services are submitted, and the services are considered part of the same service to one another, Delta Dental will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by Delta Dental.

Congenital deformities
You are not covered for services or supplies to correct congenital deformities, such as a cleft palate.

Controlled release device
You are not covered for services or supplies used for the controlled release of therapeutic agents into diseased crevices around your teeth.

Cosmetic in nature
You are not covered for services or supplies which have the primary purpose of improving the appearance of your teeth, rather than restoring or improving dental form or function.

Coverage commencing before the date the dental coverage starts.

Crowns, appliance and restorations
You are not covered for crowns that are not meant to restore form and function of a tooth, including crowns placed for the primary purpose of periodontal splinting, cosmetics, altering vertical dimension, restoring your bite (occlusion), or restoring a tooth due to allergies, attrition, abrasion, erosion and abfraction. Crowns placed on anterior teeth for endodontic purposes only are not a covered benefit.

Desensitization materials
You are not covered for desensitization materials or their application.

Diet planning
Diet planning or training in oral hygiene or preventive care.

Drugs
You are not covered for prescription, non-prescription drugs, medicines or therapeutic drug injections.

Duplicate dentures
Your plan does not cover any charges for the duplication of dentures.

Duplication of dental records
Your plan does not cover any charges for the duplication of dental records.

Effective date
You are not covered for services or supplies received before the effective date of coverage.

Experimental or investigative

You are not covered for services or supplies that are considered experimental, investigative or have a poor prognosis. Peer reviewed outcomes data from clinical trial, Food and Drug Administration regulatory status, and established governmental and professional guidelines will be used in this determination.

General anesthesia/sedation
General anesthesia and intravenous sedation are benefits only when provided in conjunction with covered oral surgery and when billed by the operating dentist.

Government programs
You are not covered for services or supplies when you are entitled to claim benefits from governmental programs (except Medicaid & the Children's Health Insurance Program).

Hospital
Charges for hospital services or hypnosis.

Incomplete services
You are not covered for dental services that have not been completed.

Indirect pulp caps
You are not covered for indirect pulp caps.

Infection control
You are not covered for separate charges for "*infection control*," which includes the costs for services and supplies associated with sterilization procedures. Participating dentists incorporate these costs into their normal fees and will not charge an additional fee for "*infection control*."

Injuries
Dental Procedures, services, treatment and supplies to treat injuries or diseases caused by riots or any form of civil disobedience, injuries sustained while committing a felony or engaging in an illegal occupation or injuries that are intentionally inflicted.

Lost or stolen appliances
You are not covered for services or supplies required to replace a lost or stolen dental appliance or charges for duplicate dentures.

Malformation
Dental or surgical procedures performed to correct developmental malformation or acquired malformation.

Medical or health plan
Dental procedures, services, treatment or supplies for which benefit is provided by a medical or health plan.

Medical services or supplies
You are not covered for services or supplies which are medical in nature, including but not limited to dental services performed in a hospital, surgical treatment centers, treatment of fractures and dislocations, treatment of cysts and malignancies, and accidental injuries or treatment rendered other than by a licensed dentist.

Medically Necessary Orthodontic Services
You are not covered for medically necessary orthodontic services unless approved by Delta Dental.

Military service
You are not covered for services or supplies which are required to treat an illness or injury received while you are on active status in the military services.

Motor vehicle injury
Dental Procedures, services, treatment and supplies for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.

Mutually exclusive service
When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), Delta Dental will pay for the service that represents the final treatment as determined by Delta Dental.

Night guard/occlusal guards/athletic guards
Your plan does not cover appliances for bruxism, grinding or clenching of teeth.

Not dentally necessary
Dental procedures, services, treatment and supplies which are not dentally necessary or which do not meet generally accepted standards of dental practice.

Oral hygiene instruction
Plaque control programs, oral hygiene instruction and dietary instructions.

Orthodontic appliances repair or replacement
Your plan does not cover for the repair or replacement of any orthodontic appliance under this contract, even if orthodontics is a covered benefit.

Payment responsibility
You are not covered for services or supplies when someone else has the legal obligation to pay for your care, and when, in the absence of this contract, you would not be charged. This may include, but not limited to, treatment of injuries intentionally inflicted or sustained while committing a criminal act as a form of civil disobedience.

Periodontal appliances
You are not covered for services or supplies for periodontal appliances (bite guards) to reduce bite (occlusal) trauma due to tooth grinding or jaw clenching.

Periodontal splinting
You are not covered for services or supplies used for the primary purpose of reducing tooth mobility, including crown-type restorations.

Pre-diagnostic services
Pre-diagnostic services, oral pathology laboratory procedures, and diagnostic tests and examinations other than pulp vitality tests.

Preventive control programs
Preventive control programs are not a covered benefit.

Prosthesis
The replacement of a prosthesis which, in the Dental Consultants opinion, can be repaired or does not need repair. The replacement of a prosthesis within 5 years after it was first placed, except

when the replacement is: (1) made necessary by the extraction of a functioning natural tooth which is replaced while covered under the policy and when the existing prosthesis cannot be made serviceable; or (2) for full or partial dentures which, while in the mouth, have been damaged beyond repair as a result of injury occurring while covered.

Provisional (temporary) crowns, bridges or dentures
You are not covered for services or supplies for provisional crowns, bridges or dentures.

Repair, replacement or duplication of orthodontic appliances
You are not covered for services or supplies required to repair, replace or duplicate any orthodontic appliance.

Same day services
When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), Delta Dental will pay for the service that represents the final treatment as determined by Delta Dental.

Sealants for primary teeth, wisdom teeth, or restored teeth
You are not covered for sealants for primary teeth, wisdom teeth, or teeth that have already been treated with a restoration. Coverage only applies to 1st and 2nd permanent molars, non-decayed, non-restored.

Sedation
Pre-medication, analgesia or conscious sedation.

Services provided in other than office setting
You are not covered for services provided in other than a dental office setting. This includes, but is not limited to, any hospital or surgical/treatment facility. This is limited to dentist's fees; no facility charges are allowed.

Specialized services
You are not covered for specialized, personalized, elective materials and techniques or technology which are not reasonably necessary for the diagnosis or treatment of dental disease or dysfunction. Specialized services represent enhancements to other services and are considered optional. Includes, but not limited to, copings and precision attachments.

Splinting
The joining of teeth to support each other for periodontal reasons (stabilization) by crowns or other means. Splinting for stabilization due to an accident or injury is a covered benefit.

Sterilization
Sterilization preparation, infection control, operatory preparation and sepsis control are considered part of all procedures and are not a benefit.

Temporary or interim procedures
You are not covered for temporary or interim procedures.

Temporomandibular joint (TMJ) dysfunction
You are not covered for expenses incurred for diagnostic x-rays, appliances, restorations or surgery in connection with temporomandibular joint dysfunction or myofunctional therapy.

Termination

Whether or not we have approved a treatment plan, you are not covered for treatment received after you or your group's coverage termination date.

Tooth colored fillings
Composite/resin restorations are allowed on the front teeth (anterior teeth) only. When composite/resin restorations are done on the back teeth (posterior teeth) they are considered optional services. Coverage will be made for a corresponding amalgam (silver) restoration.

Treatment by other than a licensed dentist
You are not covered for services or treatment performed by other than a licensed dentist or his or her employees.

Workers' compensation
You are not covered for services or supplies that are or could have been compensated under Workers' Compensation laws, including services or supplies applied toward satisfaction of any deductible under your employer's Workers' Compensation coverage.

Other:
Any procedure which (1) is for the purpose of changing vertical dimension; or (2) relates to bite registration, bite analysis, or the correction of the bite; or (3) is for replacing tooth structure lost as a result of abrasion or attrition; or (4) is for equilibration or restorations for malalignment of the teeth; or (5) gnathologic recordings.

Services for which the covered person has or had a right to payment under a program of a government or plan established by law except; (a) Medicare; (b) Medicaid; (c) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and (d) where the law does not permit this type of exclusion.

Predetermination of Benefits

A predetermination of benefits tells you and your dentist what is covered and how much will be paid on your treatment plan. It also determines that services are dentally necessary and appropriate. **Delta Dental HIGHLY recommends that a Predetermination be completed for work in excess of $250. This will assist both the patient and the dentist in knowing what will be covered prior to the services being completed.**

When to submit a treatment plan
After an examination, your dentist may recommend a treatment plan. If the plan involves crown(s), bridgework, dentures, or implants costing over $250 ask your dentist to send the treatment plan with x-rays to Delta Dental. If your dentist is a non-participating dentist, you will need to send the treatment plan, x-rays and supporting information to the address below. Delta Dental will determine benefit coverage, what portion of the cost we will pay and what portion you will be responsible for. You and your dentist will receive a predetermination of benefits form with this information on it.

The predetermination of benefits is valid for 120 days from the date issued, if you are still covered by your dental plan. Before you schedule dental appointments, you and your dentist should discuss the amount to be paid by Delta Dental and your financial obligation for the proposed treatment.

The treatment plan review
Once we receive the treatment plan and proper documentation, we will let your dentist know if the treatment plan is approved. We will take one of the following actions:

- accept it as submitted.

- recommend an alternative benefit.

- deny the treatment plan because:
    - the procedure is not a benefit under your policy;
    - you did not receive an evaluation after we asked you to; or
    - the procedure is not dentally necessary and appropriate.
    - you are no longer eligible for the services.

Appeal of Predetermination
If we deny a treatment plan, you or your dentist can resubmit it with additional documentation and ask us, in writing, to reconsider. If necessary, we will ask you to get an evaluation from another dentist. We will pay for the evaluation.

Please note: Although we may approve a treatment plan, we are not liable for the actual treatment you receive from your dentist.

Filing Claims

Once you receive dental services, we need to receive a claim to determine the amount of your benefits. The claim lets us know the services you received, when you received them, and from which dentist.

When to file your claim
After your procedure is completely finished, you should file a claim if your dentist has not filed one for you.

Reasons your claim may be denied
Even though a procedure may appear in the *Benefits* section of this policy, you should note that before you are eligible to receive benefits, we consider the following:

Is the procedure dentally necessary?
- The diagnosis is proper.

- The treatment is necessary to preserve or restore the form and the function of the tooth or teeth and the health of the gums, bone, and other tissues supporting the teeth.

Is the procedure dentally appropriate?
- The treatment is the most appropriate procedure for your individual circumstances.

- The treatment is consistent with professionally recognized standards of dental care and complies with criteria adopted by Delta Dental.

- The treatment does not cost more than alternative procedures that would be equally effective. **If you receive alternative services other than the least costly, you are responsible for paying the difference.**

Is the procedure subject to limitations or exclusions?
- Procedures that are not dentally necessary or appropriate.

- Procedures that are not covered by this policy. See *Services not Covered* section.

- Procedures that have limitations associated with them. For example, teeth cleaning is covered twice per coverage year. More frequent teeth cleaning is usually not a benefit even if your dentist verifies that it is dentally necessary and dentally appropriate. See the *Benefits* section for a description of covered procedures and limitations associated with certain procedures.

- Procedures that have reached the annual maximum benefit. See the Benefit Overview sheet at the beginning of this policy.
- Any difference between the charge and what Delta Dental allows. **Please note: This only applies if you receive services from a non-participating dentist.**

- All non-medically necessary orthodontic benefits including work in progress and take over orthodontics are subject to the Lifetime maximum benefit limitation.

Delta Dental's reply
Within 45 days of receiving all necessary documentation, we will send you a written decision and indicate any action taken.

Reviewing records
If you would like copies of records relevant to your claim, contact us at the following address or call 800-735-3379. Please allow two business days for us to process your request.

Delta Dental of Wyoming
PO Box 29
Cheyenne, WY 82003

Claim Appeals

If a subscriber is not satisfied with the results of the processing of his or her claim for benefits, the subscriber may make a written appeal. When making the request for review or reconsideration, the subscriber should include his or her ID number and claim number on the documentation.

The subscriber and/or the subscriber's authorized legal representative have up to one hundred eighty (180) days to appeal Delta Dental of Wyoming's adverse benefit determination of an authorization of services or claim for benefits. Upon receipt of an appeal from a subscriber and/or subscribers authorized legal representative, Delta Dental of Wyoming will notify the subscriber and/or the subscribers authorized legal representative of its determination within a reasonable period of time, but no later than forty-five (45 days) after receiving the request.

Note: In order to be eligible for external review, the timelines above must be followed, and the Delta Dental of Wyoming internal review process must first be exhausted.

Subscribers should mail or hand deliver their requests for an Internal Claims review to:

Delta Dental of Wyoming
6705 Faith Drive
PO Box 29
Cheyenne, WY 82009

Subscribers have the right to be represented by an attorney or other duly authorized legal

representative at any stage of their appeal. Subscribers or their authorized legal representatives have the right to review documents that pertain to their appeal. These documents are on file in the office of Delta Dental of Wyoming at the above address. Delta Dental of Wyoming will need seventy-two (72) hours' notice to assemble the documents pertaining to an appeal.

For Internal Review, the claims review committee of Delta Dental of Wyoming will review the appealed claim(s) and consider all information available pertaining to the appeal. Whether or not the initial decision is changed, subscribers will receive a written response and explanation within forty-five (45) days of Delta Dental of Wyoming receiving their request for review.

External Claims Review Procedure

If Delta Dental of Wyoming denies the subscribers request for the provision of or payment for a dental care service or course of treatment of the basis that it is not dentally necessary, or on another similar basis, the subscriber may have a right to have the adverse determination reviewed by dental care professionals who have no association with Delta Dental of Wyoming and are not the attending dental care professional or dental care professionals partner by following the procedures outlined here.

The subscriber must submit a request for external review within one hundred twenty (120) days after receipt of the claims denial to Delta Dental of Wyoming's appeal's office and after all internal review processes have been exhausted. For a standard external review, a decision will be made within forty-five (45) days of receiving the request.

This request must be made in duplicate and include a fee of fifteen dollars ($15) payable by check or money order to the Office of the Wyoming State Treasurer. This fee maybe waived for a subscriber whose income is at or below the current federal poverty guidelines and who files a financial hardship application available upon request from the Wyoming Insurance Department.

When filing a request for an external review, the subscriber will be required to authorize the release of any dental records of the subscriber that may be required to be reviewed for the purpose of reaching a decision on the external review.

Dental Necessity Denials

Expedited review: The subscriber may be entitled to an expediated review when his or her condition or circumstances require, and in any event within seventy-two (72) hours where:

- The timeframe for the completion of a standard review would seriously jeopardize the members life or health or would jeopardize his or her ability to regain maximum function; or

- The subscribers claim concerns a request for an admission, availability of care, continued stay or dental care service for which he or she received medical emergency services, but has not been discharged from a healthcare facility.

To request an external review or an expedited review, the subscriber must submit the following completed documents that accompanied his or her claims denial:

- Request form

- Release for records

- Healthcare professionals' statement of dental necessity

- Any other documents necessary

The subscribers request must be received at Delta Dental of Wyoming, 6705 Faith Drive, PO Box 29, Cheyenne WY, 82009 within one hundred twenty (120) days of the date of the Notice of Appeal Rights.

Coordination of Benefits

The purpose of this Plan is to provide certain benefits, and the rates and charges are based upon the assumption that Members often have other coverage providing duplicate benefits. In the event of other coverage, the Plan will not duplicate benefits if otherwise provided for (or should have been provided had the Member elected to claim) under any group or individual coverage by any other insurance, or government program or authorized benefits provided by private enterprise. If at any time more than one coverage shall be applicable to any benefit, the coverage first liable (primary coverage) shall pay to the full extent of its aggregate coverage, and the coverage secondarily liable shall then pay for Covered Services the unpaid balance, not exceeding its aggregate coverage or 100% of any Allowable Charges (whichever is greater), based upon the following priorities:

1. Coverage not having a coordination of benefit or non-duplication provision similar to this provision will be primary payor.

2. Group coverage will be primary over an individual policy with a non-duplication provision.

3. Coverage of a plan which covers the patient as an Employee will be primary over a plan that covers the patient as a Dependent.

4. Coverage of a plan which covers the patient as a Spouse or Civil Partner will be primary over a plan that covers the patient as a Dependent child.

5. Dependent Children: The coverage of the parent whose birth date, excluding year of birth, occurs earlier in the calendar year, will be primary payor.

6. The above applies for children, except in situations where the parents are separated/divorced or dissolved.

    a. When the parents are separated, divorced, or their civil union has been dissolved, and the parent with custody of the child has not remarried or joined into another legal civil union, the benefits of a plan covering the child as a Dependent of the parent with custody shall be primary over the benefits of a plan covering the child as Dependent of the parent without custody.

    b. When the parents are divorced or their civil union has been dissolved, and the parent with custody of the child has remarried or joined into another legal civil union, the benefits of the plan covering the child as a Dependent of the parent without custody shall be determined before the benefits of the plan covering the child as a Dependent of the stepparent will be determined before the benefits of the plan which covers that child as a dependent of the parent without custody.

c. Notwithstanding paragraphs 1 and 2 herein, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan which covers that child as a Dependent of the parent with such responsibility shall be determined before the benefits of any other plan covering that child.

7. When the application of the above guidelines is not definitive, the benefits of a plan which has covered the Member for a longer period of time shall be primary payor. Except in situations of a laid-off or retired Employee, or a Dependent of such Employee, the plan covering the Member as an active Employee will be primary, over the coverage as a laid-off or retired Employee, unless either coverage does not contain a provision for laid-off or retired Employees, then this subparagraph shall not apply.

Continuation of Coverage
If a person has continuation coverage under federal or state law and is also covered under another Plan, the following shall determine the order of benefits:

1. First, the benefits of a Plan covering the employee or member, or dependent of an employee or member.

2. Second, the benefits under the continuation coverage.

If the other Plan does not have the rule described in subparagraph (A), and if as a result, the Plans do not agree on the order of benefits, this paragraph (5) is ignored.

Effect on the Benefits of This Plan
1. In accordance with order of benefit determination rules, this plan is a secondary plan as to one or more other plans. In that event, benefits of this plan may be reduced under this paragraph so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses.

2. Reduction in this plan's benefits. The benefits that would be payable under this plan in the absence of this COB provision will be reduced by the benefits payable for the total allowable Expenses in a claim determination period under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made.

    a. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an expense incurred and a benefit payable.

    b. When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

3. No rule in other plan. If the other plan does not have rules coordinating benefits with those of this plan, the benefits of the other plan are determined first.

Right to Receive and Release Needed Information
Delta Dental has the right to decide the facts it needs to apply these rules. Delta Dental may get needed facts from or give them to any other organization or person without the consent of the Subscriber/Dependent but only as needed to apply coordination of benefits rules. Medical and dental records remain confidential as provided by applicable state and federal law. Each person claiming benefits under this plan must give Delta Dental any facts it needs to process the claim.

Right of Recovery
If the amount of the payments made by Delta Dental is more than it should have paid under coordination of benefits, it may recover the excess, at its option, from one or more of: (1) the persons it has paid or for whom it has paid; (2) insurance companies; or (3) other organizations. The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

Eligibility

1. Employees:
    a. Any employee who averages the number of hours of employment established by the Group.

2. Dependents:
    a. Spouse. A person (of the same or opposite sex of the Subscriber) to whom a person is legally married to under the laws of the state or nation that were in place at the time and in the location that the marriage was entered into.

3. Dependents:
    a. Spouse. A person (of the same or opposite sex of the Subscriber) to whom a person is legally married to under the laws of the state or nation that were in place at the time and in the location that the marriage was entered into.

    b. Civil Partner. A person (of the same or opposite sex of the Subscriber) with whom the Subscriber has entered into a civil union in a state or nation that sanctions such unions by law, and that is valid pursuant to such law at the time that the parties entered into the relationship, and who is currently a permanent resident in the home of the Subscriber. Civil Partners are eligible for coverage only if specifically permitted by the Group's policy.

    c. Child/Children. The child or children, including newborn children, stepchildren, adopted children, children which the court has decreed support to the Subscriber or the Subscriber's covered Spouse or Civil Partner and legal wards of the Subscriber or the Subscriber's covered Spouse or Civil Partner. The limiting age for covered Children is the end of the month in which age 26 is attained *unless otherwise* established by the Group.

    d. Eligibility will be continued past the limiting age for unmarried children who are BOTH incapable of self-sustaining employment and chiefly dependent upon the Subscriber, or the Subscriber's covered Spouse or Civil Partner for their support and maintenance by reason of mental or physical disability. Continuous coverage will be established at the same level of benefits. Proof of incapacity and dependency must be furnished to the Group within thirty-one (31) days of the end of the month in which the limiting age is attained. Incapacity and dependency upon the Subscriber, or the Subscriber's covered Spouse or Civil Partner, must both continue in order for the coverage to continue. Proof of such incapacity and dependency may be required from time to time. If the conditions of BOTH incapacity and dependency by reason of mental or physical disability are not continuously met, coverage will continue as required by Federal or State law as applicable.

Effective Date of Coverage

1. The effective date of coverage for a Covered Person is the effective date established by the Group.

2. The effective date of coverage for a Covered Person who enrolls during an Open Enrollment Period is January 1 of the following year.

3. The effective date of coverage for a Covered Person who enrolls during a Special Enrollment Period is the first day of the month following the event provided WEBT is notified within 30 days of the qualifying event.

Coverage of Newborn and Adopted Children

1. Your newborn child is covered from the moment of birth. A notice of birth must be submitted to WEBT within 61 days of the date of birth in order to continue coverage beyond the first 31-day period.

2. An adopted child or legal ward will be effective on the earlier of the date the petition for adoption is filed or the child's date of entry into the adoptive home (unless the child is in the custody of the State, in which case the effective date will be the date of entry of a final adoption decree by the court), for a period of thirty-one (31) days. A completed application for coverage for the child will be required before claims will be processed. The Employee may continue the coverage for the adopted child or legal ward beyond the thirty-one (31)-day automatic coverage provided that the completed application for the adopted child or legal ward is received by the employer within sixty-one (61) days of the earlier of the date of filing of the petition for adoption, or date the child enters the adoptive home (unless the child is in the custody of the State, in which case the effective date of coverage will be the date of entry of a final adoption decree by the court). NOTE: (1) The adoption or legal guardianship papers must accompany the application; (2) If coverage is made effective upon the filing of a petition for adoption, coverage will continue unless the petition is denied.

Enrollment

1. Eligible Employees must elect coverage for Eligible Persons during the Initial Enrollment Period specified in the application or during an Open Enrollment Period, if applicable, or a Special Enrollment Period, if applicable, in order to receive Benefits.

Termination of Coverage

1. Subject to any rights to continue coverage provided, enrollment under this Contract of any Covered Person may be terminated under the following circumstances:

    a. The date on which the Covered Person loses eligibility.

        i. Eligibility of employees shall terminate on the last day of the month in which employment terminates.

        ii. Eligibility of Dependents terminates on the earlier to occur of (i) the date on which the Eligible Employee through whom the Dependent has obtained coverage ceases to be an Eligible Employee or (ii) the date on which the Dependent loses Dependent status. If the loss of Eligibility is due to the Dependent attaining 26 years of age (*unless otherwise noted in your group contract*), termination of his/her coverage will occur on the last day of the month during which he/she attains 26 years of age (*unless otherwise noted in your group contract*).

b. Upon ten days' written notice if the Covered Person or his/her representative knowingly commits fraud or makes a material misrepresentation or permits another person to make a material misrepresentation in obtaining Benefits under this Contract.

2. Upon termination of a Covered Person as indicated above, no further Benefits shall be provided under this Contract.

Continued Coverage

Covered Persons in employer groups ("Qualified Beneficiaries") are permitted to elect continuation of coverage under this Contract upon the occurrence of any of the following "Qualifying Events":

1. If an employee:

    a. Termination of employment, voluntary or involuntary, except for reasons of gross misconduct; or

    b. Reduction in hours to fewer than the minimum required to be an Eligible Employee under this Contract.

2. If a Dependent of an employee:

    a. The Covered Person ceases to be a Dependent; or

    b. Death of the employee; or

    c. Termination of the employee's employment, except for reasons of gross misconduct; or

    d. Reduction in the employee's hours to less than the minimum required to be eligible to purchase Dependent coverage under this Contract; or

    e. Employee becomes entitled to Medicaid; or

    f. Parents become divorced or legally separated.

The Group must provide notice to the Covered Person of the right to elect COBRA continuation coverage.

A Covered Person whose coverage is terminated due to divorce, legal separation or cessation of eligibility for coverage must provide the Group notice of such event within 60 days of its occurrence. An election of continuation coverage must be made within 60 days beginning on the later of the date of the Qualifying Event or the date the Covered Person receives notice of election rights. The COBRA election by a Covered Person is deemed an election by all others who would lose coverage as a result of the same Qualifying Event unless otherwise specified in the election or the Qualified Beneficiary independently elects COBRA continuation coverage.

If election of COBRA continuation coverage is timely, the coverage begins on the date of the Qualifying Event and ends on the earlier of:

a. 18 months after the employee's employment termination or reduction in hours

b. 29 months after the Qualifying Event for

(i) a Qualified Beneficiary who is determined to be disabled under the Social Security Act at any time during the first 60 days of COBRA coverage and who notifies the Group of such determination within the first 18 months of COBRA coverage; and for

(ii) any nondisabled Qualified Beneficiaries with respect to the same Qualifying Event.

c. For Qualified Beneficiaries other than the employee, 36 months after the date of the initial Qualifying Event for all other Qualifying Events.

d. The date on which the Qualified Beneficiary receiving continuation in coverage fails to make a timely payment of Premium. COBRA continuation coverage will not be reinstated once terminated for nonpayment of Premium.

e. The date on which the Group ceases to offer this Contract to any of its employees or members.

f. The date on which coverage begins under another group dental plan, as applicable. However, a person who has elected COBRA continuation coverage and whose new plan contains a pre-existing limitation clause can maintain COBRA continuation coverage until all pre-existing limitations under the new plan are satisfied.

The first Premium must be paid within 45 days of the election of COBRA continuation coverage. Future Premium payments must be paid by the first day of each month. In accordance with ERISA Section 602(3), premium for a qualified disabled person will be 150% of the single, family, or other applicable Rate for the coverage during months 19 through 29 of COBRA continuation coverage. The premium for all other COBRA continuation coverage will not exceed 102% of the Rate in effect for the Group during months one through 18 and will not exceed 102% of the Rate in effect for the Group during months 19 through 36, if applicable.

Qualified Medical Child Support Order (QMCSO) – All dependent children are eligible and if they do not enroll at the time of initial eligibility they cannot be added to the plan without a qualifying event or during Open Enrollment.

If you have a dependent child and your employer receives a Medical Child Support Order recognizing the child's right to enroll in this benefit plan, your employer will promptly notify both you and the dependent that the order has been received. Your employer also will inform you and the dependent of the employer's procedures for determining whether the order is a Qualified Medical Child support Order.

Within a reasonable time after receiving the order, your employer will decide whether the court order is a qualified Medical Child Support Order and will notify you and the dependent of that determination.

Rights of Recovery (Subrogation)

WEBT has the right to recover claim payments made to you should you be compensated for damages by another party. (e.g. If you are in an accident and WEBT pays a claim for dental problems caused by the accident, WEBT may request a refund from you if you receive compensation from the other party (or their insurance company) involved in the accident.)

WEBT's Liability

In no instance is Delta Dental liable for any conduct, including but not limited to tortuous conduct, negligence, or wrongful acts or omissions by any person, including but not limited to subscribers, dentists, dental assistants, dental hygienists, hospitals or hospital employees receiving or providing services. In no instance is WEBT liable for services of facilities that, for any reason, are unavailable to you.

Notice of Privacy Practices

This section describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Confidentiality of your health care information

This notice is required by law to inform you of how Delta Dental protects the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as individually identifiable information regarding a patient's health care history, mental or physical condition or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records.

Delta Dental receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We follow the privacy practices described in this notice and federal and state privacy requirements that apply to our administration of your benefits. Delta Dental reserves the right to change our privacy practice effective for all PHI maintained. We will update this notice if there are material changes and redistribute it to you within 60 days of the change to our practices. We will also promptly post a revised notice on our website.

A copy may be requested anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Delta Dental program and will be informed on how to obtain a copy at least every three years.

Permitted uses and disclosures of your PHI

Uses and disclosures of your PHI for treatment, payment or health care operations

Your explicit authorization is not required to disclose information about yourself, or for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or plan sponsor to administer your benefits. As permitted by law, we may also disclose PHI to third party affiliates that perform services for Delta Dental to administer your benefits. As permitted by law, we may disclose PHI to third-party affiliates that perform services for Delta Dental to administer your benefits, and who have signed a contract agreeing to protect the confidentiality of your PHI and have implemented privacy policies and procedures that comply with applicable federal and state law.

Some examples of disclosure and use for treatment, payment or operations include processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Some other examples are:

- Uses and/or disclosures of PHI in facilitating treatment. For example, Delta Dental may use

or disclose your PHI to determine eligibility for services requested by your provider.

- Uses and/or disclosures of PHI for payment. For example, Delta Dental may use and disclose your PHI to bill you or your plan sponsor.

- Uses and/or disclosures of PHI for health care operations. For example, Delta Dental may use and disclose your PHI to review the quality of care provided by our network of providers.

Other permitted uses and disclosures without an authorization
We are permitted to disclose your PHI upon your request or to your authorized personal representative (with certain exceptions) when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with law, and when otherwise required by law. Delta Dental may disclose your PHI without your prior authorization in response to the following:

- Court order;

- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;

- Subpoena in a civil action;

- Investigative subpoena of a government board, commission, or agency;

- Subpoena in an arbitration;

- Law enforcement search warrant; or

- Coroner's request during investigations.

Some other examples include: to notify or assist in notifying a family member, another person, or a personal representative of your condition; to assist in disaster relief efforts; to report victims of abuse, neglect or domestic violence to appropriate authorities; for organ donation purposes; to avert a serious threat to health or safety; for specialized government functions such as military and veterans activities; for workers' compensation purposes; and, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting, provided it does not contain genetic information. Information can also be de-identified or summarized so it cannot be traced to you and, in selected instances, for research purposes with the proper oversight.

Disclosures Delta Dental makes with your authorization
Delta Dental will not use or disclose your PHI without your prior written authorization unless permitted by law. You can later revoke that authorization, in writing, to stop the future use and disclosure.

The authorization will be obtained from you by Delta Dental or by a person requesting your PHI from Delta Dental.

Your rights regarding PHI

You have the right to request an inspection of and obtain a copy of your PHI.
You may access your PHI by contacting Delta Dental at the address at the bottom of this notice. You must include (1) your name, address, telephone number and identification number, and (2) the

PHI you are requesting. Delta Dental may charge a reasonable fee for providing you copies of your PHI. Delta Dental will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or x-rays, is returned by Delta Dental to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Delta Dental does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact Delta Dental as noted below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI.
You have the right to ask that we limit how we use and disclose your PHI; however, you may not restrict our legal or permitted uses and disclosures of PHI. While we will consider your request, we are not legally required to accept those requests that we cannot reasonably implement or comply with during an emergency. If we accept your request, we will put our understanding in writing.

You have the right to correct or update your PHI.
You may request to make an amendment of PHI we maintain about you. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI.

For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact our privacy officer as noted at the end of this notice if you have questions about amending your PHI.

You have the right to opt-out of Delta Dental using your PHI for fundraising and marketing.
Delta Dental does not use your PHI for either marketing or fundraising purposes. If we change our practice, we must give you the opportunity to opt-out. We may send you newsletters or information regarding your dental program.

You have the right to request or receive confidential communications from us by alternative means or at a different address.
Alternate or confidential communication is available if disclosure of your PHI to the address on file could endanger you. You may be required to provide us with a statement of possible danger, as well as specify a different address or another method of contact. Please make this request in writing to the address noted at the end of this notice.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.
You have a right to an accounting of disclosures with some restrictions. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons, certain law enforcement purposes or disclosures made as part of a limited data set. Please contact us at the number at the end of this notice if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by e-mail.

A copy of this notice is posted on the Delta Dental website. You may also request an email copy or paper copy of this notice by calling our Customer Service department at 800-735-3379.

You have the right to be notified following a breach of unsecured protected health information.
Delta Dental will notify you in writing, at the address on file, if we discover we compromised the privacy of your PHI.

General Provisions

Entire Contract - This policy, including the application, and any amendments, riders or endorsements, constitute the entire contract of insurance.

Incontestability - The validity of the policy will not be contested after it has been in force for three years from the policy effective date, except for non-payment of premiums.

Time Limit on Certain Defenses - After three (3) years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the Group in the application for the 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 the three (3) year period.

Notice of Claim - An enrollee must give us written notice of a claim within one year after any loss covered by the policy occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice should identify the Subscriber/Dependent and their ID number.

Claim Forms - A participating dentist will submit claims for you. If you receive services from a non-participating dentist who does not file a claim for you, you can contact us at 800-735-3379 for a claim form or go to www.deltadentalwy.org. Click on "Subscribers", then "Forms". If you submit your own claim form, you will satisfy the requirements of written proof of loss by sending written or electronic proof as described below. The proof must describe the occurrence, extent and nature of the loss. You can send the claim form to:

Claims
Delta Dental of Wyoming
PO Box 29
Cheyenne, WY 82003

Proof of Loss - Written or electronic proof of loss must be sent to Delta Dental. Written or electronic proof must be given within one year after the date of loss. If it cannot be provided within that time, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity, should proof of loss be sent later than one year from the time proof is otherwise required.

Time of Claim Payment - We will pay any benefits we owe you under this policy within 45 days as long as we have received all necessary information to process the claim.

Payment of Claims - Claims for benefits shall be rejected or accepted and paid within forty-five (45) days after receipt of the proofs of loss and supporting evidence. Exceptions to the time of forty-five (45) days shall be made for claims if there is any question as to the validity or the amount of the claim.

Physical Examination and Autopsy - The Company, at its own expense, has the right and opportunity to examine the person of any individual whose loss is the basis of claim under the Policy when and as often as it may reasonably require during the pendency of the claim, and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions - No lawsuit or action in equity can be brought to recover on this policy: (1) before 60 days following the date proof of loss was given; or (2) after 3 years following the date proof of loss is required.

Change of Beneficiary - You can change the beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

Conformity with State Statutes - Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Policy is delivered is hereby amended to conform to the minimum requirements of those statutes.

Illegal Occupation - WEBT is not liable for any loss to which a contributing cause is the Subscriber/Dependent commission of or attempt to commit a felony or to which a contributing cause is the Subscriber/Dependent's engaging in an illegal occupation.

Newborn Infant Coverage - Your newborn child is covered from the moment of birth.

Non-disclosure - For the first two years from the effective date of this policy, any material misstatement, non-disclosure or concealment, whether or not such are innocent or fraudulent, in relation to any matter affecting this coverage shall render this policy void at our option.

Fraudulent Claims - The making by the Subscriber/Dependent of any fraudulent claims shall render this policy null and void from the effective date and all claims under this policy shall be forfeited.

Clerical error - If a clerical error is made, it will not affect the coverage of any Subscriber/Dependent. No error will continue the coverage of a Subscriber/Dependent beyond the date it should end under this policy terms.

Not in lieu of Workers' Compensation - This policy is not a Workers' Compensation policy. It does not provide Workers' Compensation benefits.

Payment of Benefits - Benefits are payable to the Subscriber/Dependent or to his designated beneficiary(ies) or to his estate. If the Subscriber/Dependent is a minor or otherwise not competent to give a valid release, the benefits may be made payable to his parent, guardian or other person actually supporting him.

The following is included in this document as per Section 1557 of the Affordable Care Act (ACA):

Notice of Non-Discrimination

Delta Dental of Wyoming (DDWY) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. DDWY does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

DDWY provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Written information in other formats (large print, audio, accessible electronic formats, other formats)

DDWY 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, contact the DDWY Compliance Department at 800-735-3379.

Language Assistance Services

ATTENTION: If you speak any of the languages below, language assistance services, free of charge, may be available to you. Contact 800-735-3379 or 307-632-3313.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-735-3379 or 307-632-3313.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-735-3379 or 307-632-3313.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-735-3379 or 307-632-3313.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-735-3379 or 307-632-3313.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-735-3379 or 307-632-3313.

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。**800-735-3379 or 307-632-3313**まで、お電話にてご連絡ください。**

D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 800-735-3379 or 307-632-3313

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800-735-3379 or 307-632-3313。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-735-3379 or 307-632-3313.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-735-3379 or 307-632-3313번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-735-3379 or 307-632-3313.

PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi 800-735-3379 or 307-632-3313.

ध्यान □दनुहोस:् तपाइ□ले नेपाल□ बोल्नहन्छ भन तपाइ□को □निम्त भाषा सहायता सवाहरू □नःशल्क रूपमा उपलब्ध छ । फोन गनुहोसर् 800-735-3379 or 307-632-3313

ચુના: જો તમે □જરાતી બોલતા હો, તો ◌િન:□લ્કુ ભાષા સહાય સેવાઓ તમારા માટ□ ઉપલબ્ધ છ. ફોન કરો 800-735-3379 or 307-632-3313.

توجه: اگر به زبان فارسگفتگو می‌سو ینک می‌مد لایهستت زصبد می‌نابت‌رو اراگین بیار امشد فمهار شاد می‌مد. با 800-735-3379س یگیرید. امتة or 307-632-3313