Delta Dental PPO
Schedule of Benefits
ENHANCED PLAN

Control Plan - Delta Dental of Colorado
Benefit Year – Policy Year

	PPO Provider	Delta Dental Premier Provider	*Non-Participating Provider	
Covered Services	**Plan Pays**	**Plan Pays**	**Plan Pays**	**Waiting Period**
Type I - Diagnostic & Preventive Services				
Oral Exams and Cleanings	100%	100%	100%	NONE
X-Rays	100%	100%	100%	
Sealants	100%	100%	100%	
Fluoride Treatments	100%	100%	100%	
Type II - Basic Services				
Basic Restorative (Fillings)	80%	80%	80%	6 MONTHS
Simple Extractions	80%	80%	80%	
Type IIIA - Major Services				
Complex Oral Surgery	50%	50%	50%	12 MONTHS
Denture Repair/Relines/Rebases	50%	50%	50%	
Endodontics (Root Canal Therapy)	50%	50%	50%	
Periodontics (Gum Disease Treatment)	50%	50%	50%	
Type IIIB – Major Services				
Implants	50%	50%	50%	12 MONTHS
Special Restorative (Crowns)	50%	50%	50%	
Prosthodontics (Dentures, Bridges)	50%	50%	50%	

Orthodontia is not a covered benefit.

*** Important: Non-Participating Providers are allowed to balance bill. Employees and/or Dependents are responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the Provider.**

Age

Type	Age Limit	Coverage Thru
Dependent	26	Month

Deductible (Policy Year)

Class	Type	Network	Amount
All Covered Classes Except D&P	Individual coverage amount	PPO and Non-PPO	$50

Annual Maximum (Policy Year)

Class	Type	Network	Amount
All Covered Classes	Individual coverage amount	PPO and Non-PPO	$1000

Under this Delta Dental PPO plan, you may visit any Provider of your choice. There are three levels of Providers to choose from who are located nationwide:

PPO Participating Provider
Advantages of seeing a PPO Provider include:

- Payment is based upon the PPO Provider's Allowable fee, or the fee actually charged, whichever is less.
- Claim forms are submitted directly to Delta Dental by Providers.
- You are responsible for any applicable deductible, and coinsurance for covered procedures.

You will receive the best benefits available on this plan by choosing a PPO Provider.

Premier Participating Provider (Non-PPO)
You have the option of seeing a Premier Provider, but you may incur additional costs:

- Payment is based upon the Premier Maximum Plan Allowance, or the fee actually charged, whichever is less.
- Claim forms are submitted directly to Delta Dental by the Providers.
- You are responsible for any applicable deductible, and coinsurance for covered procedures.

Non-Participating Provider (Non-PPO)
You have the option of seeing a non-participating Provider, but you may incur additional out-of-pocket costs.

- You may be responsible for payment in full to the Provider and for filing your claim with Delta Dental for reimbursement.
- You are responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the Provider.
- You are responsible for any applicable deductible, and coinsurance for covered procedures.

COVERED AMOUNT means:

- For PPO Providers, the lesser of the PPO Provider’s Allowable fee or the fee actually charged.
- For Premier Participating Providers, the lesser of the Premier Maximum Plan Allowance, or the fee actually charged.
- For all other Providers, the lesser of the Non-Participating Maximum Plan Allowance, or the fee actually charged.

Colorado counties without PPO or Premier providers are Crowley, Gilpin, Jackson, Kiowa, Mineral, San Juan, and Sedgwick.

CONTACT US

Visit Delta Dental's Website:
www.deltadentalcoversme.com

You can search for a Provider or
access other personal account information.

Delta Dental
P. O. Box 103
Stevens Point, WI 54481-0103

Email: customerservice@deltadentalcoversme.com

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ELIGIBILITY

SUBSCRIBER: The Subscriber is a Member in whose name the policy is created, is eligible for benefits on his or her own behalf and not by Dependent status, and who meets the eligibility requirements as a Subscriber, and is a Colorado resident age 18 or older who has no other insurance covering dental procedures.

This policy is effective at 12:00 a.m. on the date of enrollment, and will continue through 11:59 p.m. on the date of termination.

DEPENDENTS: For your dependents to be insured, you will have to pay the required premium for the cost of having dependents on your insurance. Your dependents will be insured only if you are insured.

A subscriber's Dependents may include the following:

- The Subscriber's **lawful spouse**, including **common law spouse**, **domestic partner,** or **civil union partner**.
- Newborn Child.
- Adopted Child. An unmarried child under the age of 26 years.
- A **Dependent child** under the Dependent Age Limit of 26 years of age. Eligible children are natural children, stepchildren, those under court-ordered guardianship, adopted children and foster children. A son or daughter of a Subscriber's Domestic Partner or Civil Union Partnership, including a legally adopted individual or an individual who is lawfully placed with the Subscriber's Domestic Partner for legal adoption, or a child for whom the Subscriber's Domestic Partner has established parental responsibility.
- **Disabled Dependent Child**. A Dependent child who reaches the Dependent Age Limit of 26 and who is not capable of self-support because of physical or mental disabilities. The disabilities must have been present when the child reached the Dependent Age Limit. The child must be dependent on the Subscriber. Delta Dental may request proof of disability and dependency each year. Failure to submit such proof will terminate coverage.

No one may be covered as a Dependent and as a Subscriber under this plan. If both parents are covered as Subscribers, children may be covered as Dependents of one parent only.

Benefits for a Dependent Child will continue until the last day of the calendar month in which the limiting age is reached.

Persons in active military service are not eligible Dependents.

Dependents of an eligible Subscriber must enroll within 30 days of the following:

- The date the Subscriber becomes eligible to enroll. The effective date is that of the subscriber.
- The date upon which he or she becomes a Dependent of the Subscriber via marriage, birth, adoption, or placement for adoption. The coverage for such a person shall be effective the first day of the month following the date the person becomes a Dependent.
- If you enroll and have family coverage, a newborn child is covered at birth and coverage continues for 60 days. You have a year to add the newborn to the policy if you pay the premium plus 5 ½% interest. The policy will pick up coverage at any point during the newborn's first year of life.
- The date the Plan is amended to provide Dependent coverage. The Plan becomes effective on the first day of the month following this change.
- The date upon which they lose coverage through another source, if they show proof of loss. (Loss of coverage is any loss due to death, divorce, loss of job, or termination of benefits by the subscriber).

PAYING YOUR PREMIUM

You are responsible for paying premiums. The first premium is due the day we accept your application for coverage. You can pay premiums monthly, semiannually or annually. That time is called a "premium period". Premiums are due on the 27th day of each premium period. If the charge is declined on the due date, we will tell you and you have to take care of paying the premium. If at the end of a 31-day grace period your account is still overdue, we will cancel your coverage.

GRACE PERIOD

Unless not less than thirty days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured's last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted, a grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS (Applicable to Managed Care Plans)

How to Find a Provider

There are two easy ways to find out if your Provider is a Delta Dental PPO Network Provider.

1. **Visit our website at** www.DeltaDentalCoversMe.com **or**
2. **Phone our automated call center** at 1-888-899-3734.

The network is subject to change. Please check on the status of your Provider before your next treatment.

You need not obtain approval before being treated. Before starting treatment that may cost $400 or more, you may request a coverage estimate from Delta Dental. Pre-treatment estimates are not required.

BENEFITS/COVERAGE (What Is Covered)

COVERED DENTAL SERVICES

Only the procedures listed below are covered. Treatments not listed are not covered and Plan provides no alternate benefit.

TYPE I - DIAGNOSTIC & PREVENTIVE SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Oral Exam (All exam types)	One exam in any 6 month period is covered. One comprehensive oral exam is covered per covered person per dental office. There is no separate benefit for diagnosis, treatment planning or consultation by the treating provider.
Dental Cleaning	One cleaning in any 6 month period is covered. Not covered within 6 months of a periodontal maintenance procedure.
Bitewing x-rays	Covered one time in a 12 month period.
Complete Mouth Survey or Panoramic x-ray	Covered one time in a 60 month period.
Individual Periapical x-rays	A maximum of 4 periapical x-rays are covered in a 12-month period.
Fluoride Treatment	Covered once in a 12 month period for children through age 14.
Sealants	Allowed for the occlusal (chewing) surface of decay-free unrestored permanent first and second molars. Covered once per tooth for children through age 14. There is no separate benefit for preparation of the tooth or any other procedure associated with the sealant application. Deductible applies to this service.
Preventive Resin Restoration	Covered as a sealant above.
Space Maintainer	Covered for children through age 14 to maintain space left by prematurely lost baby back teeth.

TYPE II - BASIC SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Amalgam Fillings (silver fillings)	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing amalgam filling is allowed if at least 24 months has passed since the existing amalgam was placed.
Composite Resin (white plastic) Fillings	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing composite resin filling is allowed if at least 24 months have passed since the filling was placed. Composite resin fillings on back teeth will be covered up to the cost of an amalgam filling.
Protective Filling	Covered if no other restorative service is performed on the same tooth on the same date. Not covered during a course of endodontic therapy.
Extraction -coronal remnants deciduous tooth	Includes local anesthesia and routine post-operative care, which are not covered separately.
Extraction, erupted tooth or exposed root	Includes local anesthesia and routine post-operative care, which are not covered separately.
Palliative Treatment	Covered as a separate benefit if no other service is performed during the visit except an exam and/or x-rays. Deductible applies to this service.

TYPE IIIA - ENDODONTIC SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Therapeutic Pulpotomy	Covered for baby teeth.
Root Canal Therapy	Covered once per tooth every 24 months. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Repeat Root Canal therapy	Covered if the first root canal procedure on the same tooth was performed at least 24 months earlier.

Apexification/recalcification/pulpal regeneration	Covered once per root. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Apicoectomy	Covered once per root each 24 months. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Retrograde Filling (per root)	X-rays, cultures, tests, local anesthesia and routine follow-up care are not covered separately.
Root Amputation (per root)	X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Hemisection (includes any root removal)	X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.

TYPE IIIA - PERIODONTIC SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Periodontal Scaling and Root Planing - Per Quadrant	Covered one time per quadrant of the mouth in any 24 month period.
Periodontal Maintenance Procedures Following Active Therapy	Covered if 3 months have passed since the completion of active periodontal therapy (gum surgery or scaling and root planning). Then one time in any 6 month period. Not covered if performed within 6 months of a routine cleaning.
Gingivectomy	If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Gingival Flap Procedure	If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant, Root planing, local anesthesia and routine post-operative care are not separately covered.
Crown lengthening-hard tissue, by report	Not covered if performed on the same date as surgery to bone structures, crown preparation or other restoration.
Osseous Surgery, Guided tissue regeneration (includes surgery and re-entry), Pedicle Soft Tissue Graft, Free Soft Tissue Graft (Including Donor Site)	If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Local anesthesia and routine post-operative care are not separately allowed as benefits.

TYPE IIIA - COMPLEX ORAL SURGERY

PROCEDURE	BENEFIT DESCRIPTION
Surgical Extractions of teeth, or tooth roots	Local anesthesia and routine post-operative care are not separately allowed as benefits.
Oral Surgery Services	Includes fistula closure, sinus perforation closure, tooth reimplantation, surgical access to expose teeth, biopsies, soft-tissue lesion removal, excision of bone tissue and surgical incisions, and cyst removal. Local anesthesia and routine post-operative care are not separately covered.
Alveoloplasty	Not allowed as a separate benefit when performed on the same date as extractions. Includes local anesthesia and routine post-operative care.

TYPE IIIA - PAIN MANAGEMENT

PROCEDURE	BENEFIT DESCRIPTION
General Anesthesia	Allowed as a separate benefit when provided for covered oral surgical procedures.
I.V. Sedation	Allowed as a separate benefit when provided for covered oral surgical procedures.

TYPE IIIA - ADJUSTMENT AND REPAIRS

PROCEDURE	BENEFIT DESCRIPTION
Re-Cement Crowns	Covered one time per tooth after 6 months from initial insertion.
Repairs to Crowns	Subject to Delta Dental's consultant review.

Re-Cement Fixed Bridges	Covered one time per tooth after 6 months from initial insertion of fixed bridge.
Repairs to Fixed Bridges	Subject to Delta Dental's consultant review.

TYPE IIIA - DENTURE ADJUSTMENT, REPAIR, RELINE AND REBASE

PROCEDURE	BENEFIT DESCRIPTION
Denture Adjustments	Covered after 6 months from the insertion of the complete or partial denture.
Repairs to Full and Partial Dentures	Covered after 6 months from the insertion of the complete or partial denture.
Tissue Conditioning Per Denture Unit	A separate fee for tissue conditioning is DISALLOWED if performed by the same dentist/dental office on the same day the denture is delivered or a reline/rebase is provided.
Relining Dentures Rebasing Dentures	Relining or rebasing (but not both) is covered at least 6 months after the initial insertion of a complete or partial denture and then not more than one time in a 12 month period.

TYPE IIIB - IMPLANTS AND CROWNS

(Temporary restorations and appliances are not covered separately.)

PROCEDURE	BENEFIT DESCRIPTION
Crowns	Covered when the tooth cannot be restored by an amalgam or composite filling and if more than 84 months since the last placement for persons age 12 and older. This time limit applies even if the existing crown was not provided under this Plan.
Stainless Steel Crowns, Resin Crowns	Covered when the tooth cannot be restored by a filling on primary teeth. Replacement on the same tooth covered once every 24 months.
Interim Therapeutic Restoration	Covered once per lifetime and only on primary teeth.
Core (Crown) Buildup including any pins	Covered when needed to retain a crown when need is due to extensive loss of tooth structure caused by decay or fracture. Replacement on the same tooth covered once every 84 months.
Pin Retention	Covered with a basic (amalgam or composite) filling. A benefit one time per filling.
Post and Core (in conjunction with a Crown)	Must be needed to retain a crown, and when necessary due to extensive loss of tooth structure caused by decay or fracture. Replacement on the same tooth covered once every 84 months.
Implants-Surgical Placement & Restoration	The placement of the surgical implant, and the placement of a crown, full or partial denture, or bridge over the implant, are covered once in 84 months for restorations involving the same tooth. This limitation includes any prior Special Restorative or Prosthodontic benefits for the same tooth.

TYPE IIIB - FIXED BRIDGEWORK

PROCEDURE	BENEFIT DESCRIPTION
Fixed Bridges (covered to replace a Functioning Natural Tooth that was pulled while the patient was covered under this Plan.)	Replacement of an existing fixed bridge is covered for persons 16 and older if the existing fixed bridge is more than 84 months old, is not serviceable, and cannot be repaired. This time limit applies even if the existing fixed bridge was not provided under this Plan.
Core (Bridge) Buildup including any pins (in conjunction with a Bridge Abutment)	Covered when needed to retain a fixed bridge and when needed due to extensive loss of tooth structure caused by decay or fracture.
Post and Core (in conjunction with a fixed bridge)	Covered for endodontically treated teeth. Must be needed to retain a fixed bridge, and when necessary due to extensive loss of tooth structure caused by decay or fracture.

TYPE IIIB - DENTURES AND PARTIAL DENTURES

PROCEDURE	BENEFIT DESCRIPTION
Full Dentures (A benefit if it includes the replacement of at least one Functioning Natural Tooth that was extracted while the patient was covered under this Plan.)	Replacement is covered after 84 months from the last placement. Dentures must not be able to be repaired for persons 16 and older. The time limit applies even if the existing full denture was not provided under this Plan. Personalized dentures, overdentures or associated procedures are not covered.
Partial Dentures (A benefit to replace a Functioning Natural Tooth that was extracted while the patient was covered under this Plan.)	Replacement is covered after 84 months have elapsed since the last placement for persons age 16 and older. Dentures must not be able to be repaired. The time limit applies even if the existing partial denture was not provided under this Plan. Precision or semi-precision attachments are not covered. The benefit for a partial denture includes any clasps and rests and all teeth.

LIMITATIONS/EXCLUSIONS
(What Is Not Covered)

GENERAL LIMITATIONS – ALL SERVICES

a. Alternate Benefits
Often more than one service or supply can be used for treatment. In deciding the amount allowed on a claim, Plan will consider other materials and methods of treatment. Payment will be limited to the Covered Amount for the least costly Covered Service that meets accepted standards of dental care as determined by Delta Dental. The covered person and his Provider may decide on a more costly treatment. Delta Dental will pay toward the cost of the selected procedure at the Coinsurance level shown on the Schedule of Benefits. Payment will be limited to the Covered Amount for the least costly treatment. **Only covered services will receive alternate benefits.**

b. Temporary services will be covered as part of the final service. The benefit allowed for such service and the final service is limited to the benefit allowed for the final service.

c. Plan will pay procedures performed at the same time and as part of a primary procedure at the amount allowed for the primary procedure.

d. Services are covered when provided by a person legally permitted to perform such Services and are determined to be Necessary and appropriate. Benefits will be based on the terms of the plan and Delta Dental's Processing Guidelines, even if no monies are paid.

e. Pre- and post-operative procedures are considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.

f. Local anesthesia is considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.

g. The Covered Amount for a Covered Service Started but not Completed will be limited to the amount determined by Delta Dental.

h. Allowance for an assistant surgeon, when determined by Delta Dental to be a Covered Service, will not exceed 20% of the surgeon's fee for the same Covered Service.

i. Services related to another category of Covered Services will be covered at the same percentage as the related category of Covered Services.

EXCLUSIONS

a) Any Service Started when the person was not covered.

b) Services for treatment of birth or developmental defects, ***except*** Services within the mouth for treatment of a condition related to cleft lip and/or cleft palate. (See Definition of Medically Necessary Orthodontic Services.)

c) Any treatment provided primarily for cosmetic purposes. Veneers on teeth and facings or veneers placed on crowns or bridge units for teeth after the first molar will always be considered cosmetic. Delta Dental will limit their allowance to a Covered Service without facings or veneers and the patient is responsible for the remainder of the Provider's approved fee.

d) Services to treat tooth structure lost from wear, erosion, attrition, abrasion or abfraction.

e) Services resulting from improper alignment, occlusion or contour.

f) Services related to periodontal stabilization of teeth (splinting).

g) Habit appliances, night guards, occlusal guards, athletic mouth guards and jaw function services, bite registration or analysis, or any related services.

h) Patient management services (***except*** covered anesthetic services).

i) Charges for prescribed drugs.

j) Inlays and onlays.

k) Any Experimental or Investigational Procedures.

l) Services that may otherwise be covered, but due to the patient's condition would not prove successful to improve the patient's oral health.

m) Any treatment done in anticipation of future need (***except*** covered preventive services).

n) Hospital costs or any charges for use of any facility.

o) Any anesthesia service not included in Covered Services.

p) Grafts done in the mouth where teeth are not present.

q) Grafts from outside the mouth into the mouth.

r) Orthodontic Services.

s) Therapy for speech or the function of the tongue or face.

t) Treatment of any temporomandibular joint (TMJ) problems. Includes facial pain, or any related conditions. Any related diagnostic, preventive or treatment Services.

u) Services not performed in accordance with Colorado state law. Services by any person other than a person licensed to perform them. Services to treat any condition, other than an oral or dental disease, abnormality or condition.

v) Teaching services.

w) Completion of forms. Providing diagnostic information. Copying of records.

x) Replacement of lost, stolen or damaged items.

y) Repair of items altered by someone other than a Provider.

z) Any Services not included in Covered Services.

aa) Services for which charges would not have been made but for this coverage, except for Services provided under Medicaid.

bb) Missed appointment charges.

cc) Preventive control programs, including home care items.

dd) Plaque control programs.

ee) Self-injury.

ff) Initial placement of a denture unless needed to replace at least one Functioning Natural Tooth pulled while the

Person was covered under this plan. One full or partial denture is covered per arch in any 84-month period.

gg) The first fixed bridge unless it is needed to replace a Functioning Natural Tooth pulled while the Person was insured under this plan. And if that tooth was not an abutment to an existing fixed bridge which is less than 84-months old. If a bridge replaces more than one pulled permanent Natural Tooth, benefit will be limited to the replacement of those teeth which were pulled while the Person was covered under the plan.

hh) Replacement of a complete denture, partial denture, or fixed bridge is not a Covered Service unless:

1. replacement of the current denture occurs at least 84 months after the date of insertion, even if the existing appliance was not provided under this plan; or
2. replacement of an existing fixed bridge occurs at least 84 months after the date of insertion, even if the existing appliance was not provided under this plan; or
3. the replacement appliance is required by the Necessary extraction of a Functioning Natural Tooth while the Person is covered; or
4. the replacement is made Necessary by a covered Dental Injury to Sound Natural Teeth provided the treatment is Started within 60 days of the injury. (Chewing injuries are not considered covered Dental Injuries).

ii) The replacement of a fixed bridge unless the existing fixed bridge is at least 84 months old, cannot be serviced, and cannot be repaired. This requirement applies even if the existing fixed bridge was not provided under this plan.

jj) The replacement of an existing crown or other cast restoration, unless the existing cast restoration is at least 84 months old, is not serviceable and cannot be repaired. The time requirement applies even if the existing cast restoration was not provided under this plan.

kk) Prefabricated resin crowns are a benefit on front teeth. Replacement of a prefabricated crown is not covered within 24 months of the placement of an existing prefabricated crown.

ll) No benefit will be provided for temporary partial dentures. Charges for temporary partial dentures are not covered.

mm) Bone grafting when done in the same site as a tooth extraction, implant, apicoectomy or hemisection.

nn) Provisional splinting.

MEMBER PAYMENT RESPONSIBILITY

You must pay deductibles, amounts above the annual maximum, and your coinsurance. You must pay charges for Services not covered. You are responsible for the premium.

CLAIM PROCEDURES (How to File a Claim)

Delta Dental will not pay claims submitted more than 15 months after the date of service.

There is no Coordination of Benefits under this dental plan.

PRE-TREATMENT ESTIMATE

Before starting treatment that may cost $400 or more, you may request an estimate of what is covered. Pre-treatment estimates are not required.

CLEAN CLAIM

Delta Dental shall pay clean claims within thirty calendar days after receipt by Delta Dental if submitted electronically and within forty-five calendar days after receipt by Delta Dental if submitted by any other means.

If the resolution of a claim requires additional information, Delta Dental shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by Delta Dental within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, Delta Dental may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by Delta Dental within 90 days.

Absent fraud, all claims other than clean claims shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

RIGHT TO EXAMINATION

Delta Dental shall have the right and opportunity to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the policy.

GENERAL POLICY PROVISIONS

10-DAY FREE LOOK

If you are not satisfied with this policy, you can return it anytime within 10 days of the day you received it. We will void the policy and refund your money, less any payment for claims you incurred.

NON-DISCRIMINATION

With regard to participation in its networks, Delta Dental does not discriminate against any provider acting in the scope of his or her license.

2-YEAR LOCKOUT

If your coverage under this policy is terminated for any reason, and not reinstated by us prior to the coverage expiration date, you cannot sign up for a Delta Dental individual policy for 24 months from the date of termination.

SUBROGATION

Delta Dental has the right to enforce on its own, or with a covered person, a claim against a third party up to the amount paid by Delta Dental. If Delta Dental pays a claim for injuries to a covered person and the covered person settles with a third party for an amount that includes such costs, the covered person must refund Delta Dental the amount equal to the benefit payment made to, or on behalf of, the covered person.

HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, Delta Dental has agreed to:

a) Not use or disclose health information other than as permitted or as required by law.
b) Ensure that any agents who receive protected health information (PHI) agree to the same restrictions.
c) Not use or disclose PHI for employment actions and decisions.
d) Report to the Plan any improper use or disclosure of PHI that they are aware of.
e) Make PHI available for your own use and provide you with the right to amend or correct your own PHI upon request.
f) Provide an accounting of its disclosures to individuals and make its practices relating to the use or disclosure of PHI available to the Secretary of HHS.
g) Ensure that there is separation between the Individual and the Plan as required by HIPAA. Ensure that there are reasonable security controls.
h) If possible, return or destroy all PHI received from the Plan when no longer needed.
i) Implement safeguards that protect electronic PHI that is managed on behalf of the individual health plan.
j) Ensure that any agent to whom it provides electronic PHI.
k) Report to the individual health plan any security incident of which it becomes aware.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can access this information.

Delta Dental is required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are committed to protecting your health information. This notice is effective on the date your coverage went into effect.

How We May Use and Disclose Health Information About You

In almost all cases, we may use and disclose protected health information for treatment, payment, and health care operations. For example, we may use and disclose protected health information:

1. To communicate with the provider who provides, coordinates, or manages your care,
2. To determine how much or whom we should pay for covered services,
3. To assess the quality of care that our participating providers provide.

Other categories describing how we may use and disclose your health information are listed below, along with some examples of these uses and disclosures.

To You and With Your Written Authorization: We may disclose your health information to you in the manner and for the purposes described in the "Your Rights" section of this Notice. You may revoke your authorization in writing at any time. Your revocation will not affect any use or disclosure permitted by your prior authorization while it was in effect. Without your written authorization, we may not use or disclose your protected health information to any person or for any reason not permitted by law.

An authorization is required for uses and disclosures of protected health information for marketing purposes and disclosures that constitute a sale of protected health information. Any other uses and disclosures not specifically described in this notice will be made only with the individual's authorization.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person if you provide us written authorization to do so.

Health Related Benefits and Services: We may use or disclose health information about you to communicate to you about health-related benefits and services.

Research: We may use or disclose health information about you for research purposes. If we do, Delta Dental may be required to obtain an authorization from you for such use or disclosure.

Public Health and Safety: For example, to prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.

Required by Law: For example, as required by federal or state statute or regulation, worker's compensation or similar laws and state insurance and health regulatory authorities.

Lawsuits and Disputes: For example, in the course of any administrative or judicial proceeding.

Law Enforcement: For example, to identify or locate a suspect or to comply with a court order, a court ordered warrant, or a subpoena or summons issued by an officer of the court.

Military and National Security: For example, military, lawful intelligence, counter-intelligence, and other national security activities.

Your Rights Regarding Health Information About You

You have the following rights regarding health information we maintain about you:

- **Your Right to Inspect and Copy Your Health Information:** To inspect and copy such information, you must submit your request in writing. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request.
- **Your Right to Amend Protected Health Information:** You may request that Delta Dental change your health information, although we are not required to do so. If your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make your request in writing. You must also provide a reason for your request.
- **Your Right to an Accounting of Disclosures Made by Delta Dental:** You may request an accounting of disclosures made for purposes other than treatment, payment, health care operations or made to you. You must submit your request in writing. Your request should specify a time period of up to six years and may not include dates before April 14, 2003. Delta Dental will provide the first accounting per 12-month period free of charge; we may charge you for additional reports.
- **Your Right to Request Restrictions on Uses and Disclosures:** Although you have this right, Delta Dental is not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing.
- **Your Right to Request Confidential Communications Through a Reasonable Alternative Means or at an Alternative Location:** To request confidential communications, you must submit your request in writing. We are not required to agree to your request, unless such disclosure could cause you to be in danger.
- **Your Right to a Paper Copy of this Notice:** You may obtain additional paper copies of this Notice by sending us a written request. You may also obtain a copy of this Notice at our website www.deltadentalco.com.
- **Your Right to Opt Out of Fundraising Communications:** Delta Dental does not intend to contact you to raise funds, but if it does engage in fundraising, you have the right to opt-out of receiving any fund raising communications.
- **Your Right to Breach Notification:** You have the right to be notified of a breach of unsecured protected health information. Delta Dental will provide you the date and description of the information disclosed. You will be notified who the information was disclosed to if we are able. You will be notified by mail within 60 days from the date that we discover the breach.
- **Your Right to Obtain Additional Information or File a Complaint:** Send us a written request if you would like to have a more detailed explanation of these rights. Complaints about how we handle your health information should be submitted in writing. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. Delta Dental will not retaliate against you in any way if you choose to file a complaint with us or with the department.

Genetic Information Nondiscrimination Act: Delta Dental is prohibited from using or disclosing genetic information for underwriting purposes.

Changes to this Notice

Delta Dental can amend this Notice at any time in the future and make the new Notice provisions effective for all health information that we maintain. We will promptly revise our Notice and distribute it to you whenever we make significant changes. Delta Dental is required by law to comply with the current version of this Notice.

Send Written Requests Regarding this Privacy Notice to:

Privacy Officer
PO Box 5468
Denver CO 80217-5468
Or You May Call: 1-800-233-0860

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

TERMINATION/NONRENEWAL/ CONTINUATION

A Subscriber's plan will terminate at the earliest of:

- The date the Subscriber is not eligible for coverage under the terms of this policy.
- The date the benefits described in the Policy are terminated.
- When the required premium has not been paid (subject to the applicable grace period).
- When you commit fraud or intentional misrepresentation of material facts.
- The date the Subscriber enters full-time military service of any country.
- Upon the Subscriber's death.

To remove a Dependent from the plan, the Subscriber must notify us of the termination. The Effective Date of the change will be the end of the month in which the change was received. We reserve the right to recover any benefits payments made for dates of service after the termination date.

Benefits for a Dependent ends on the last day of the month for the following life changing events:

- The date the benefits described in the policy are terminated.
- The date the Dependent is not eligible for coverage under the terms of this policy.
- When the Dependent child no longer qualifies as a Dependent by definition.
- When legal custody of a child placed for adoption is terminated.
- When the required premium has not been paid.
- Upon the Dependent's death.

EXTENDED COVERAGE
(Paying for Benefits after Termination)

Delta Dental benefits will end if this Policy is terminated or if a person's coverage is cancelled. Delta Dental will cover no further Services except as described below.

If a Covered Service started before coverage ends, but the Covered Service is completed after coverage ends, Delta Dental will pay Benefits for the Covered Service as follows:

- Benefits will be paid in the amount that would have been paid and subject to the same terms as would have applied if the Person's coverage were still in effect.
- Benefits will be paid only if the Covered Service is completed within 60 days after the date the Person's coverage ended.

No benefit will be paid if the Covered Service is started after coverage ends.

NONRENEWAL

This policy will automatically renew. If you don't want to renew this policy, contact Delta Dental before the policy's renewal date. If you do not renew this policy, the policy will end on the last day before the renewal date. Delta Dental can nonrenew this policy by sending you written notice (either electronically or through the mail) at least 60 days before the renewal date. If we do, this policy will end on the last day before the renewal date.

The right to refuse renewal shall not be exercised before the renewal date occurring on, or after and nearest, each anniversary or, in the case of lapse and reinstatement at the renewal date, occurring on, or after and nearest, each anniversary of the last reinstatement and that any refusal of renewal shall be without prejudice to any claim originating while the policy is in force. In addition, insurer shall not refuse to renew the policy on an individual basis after two years from its date of issue or, in the event the policy has been reinstated, two years from the date of its last reinstatement and before the age or other limitation upon renewal stated in the policy solely because of deterioration in the physical or mental condition or the health of any person covered thereunder.

APPEALS AND COMPLAINTS

Internal Appeal Process - First Level Appeals:
A Subscriber may appeal an adverse claim decision within 180 days of the date of the original Explanation of Benefits by writing to:

Delta Dental
Appeals Analyst
P.O. Box 103
Stevens Point, WI 54481-0103

A Subscriber may submit additional information in support of the appeal.

Appeals are reviewed by an impartial Provider of the same or similar specialty as would typically manage the case being reviewed. The reviewing provider will not have been involved in the initial decision.

The decision will be sent to the Subscriber with the rationale for the decision. The decision will be made within 15 calendar days for pre-service denials. Post-service decisions will be made within 30 calendar days.

Internal Appeal Process - Expedited Appeals:
Subscribers may request an expedited appeal when the time for a standard review would seriously jeopardize the life or health of the Subscriber, would jeopardize the Subscriber's ability to regain maximum function, or, for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently.

Expedited review decisions will be issued within 72 hours.

Independent External Review:
Where Delta Dental makes an Adverse Determination and the Subscriber exhausts the internal appeals process, the Subscriber has the right to request an external review. Delta Dental will notify the Subscriber of the right, if any, to request an external review after the First Level appeal.

Requests for an independent external review must be in writing. They must include a completed external review request form as specified by the Colorado Division of Insurance. The Subscriber must submit the request within four months of the completion or exhaustion of the internal appeals process. The internal appeals process is completed or exhausted upon Subscriber's receipt of notice of the adverse determination or upon Delta Dental's failure to comply with Colorado Revised Statues §§ 10-16-113, 10-16-113.5, or Colorado Insurance Regulations 4-2-17 or 4-2-21.

Subscriber may request expedited external review. All requests must be submitted to:

Delta Dental
Appeals Analyst
P.O. Box 103
Stevens Point, WI 54481-0103

A signed consent authorizing Delta Dental to disclose protected health information pertinent to the external review is also required.

Delta Dental adheres to timeframes set forth by Colorado Regulation 4-2-21 in the processing of Independent External Reviews. Within 45 days after the receipt of the request for external review (72 hours for expedited external review), the external review entity shall deliver a written decision to the Subscriber, Delta Dental, the provider, and the Commissioner.

INFORMATION ON POLICY AND RATE CHANGES

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 the insurer 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.

If there are changes to the benefits under this plan or to the premium amount you must pay, whether due to a change in the agreement between you and Delta Dental or due to changes to the plan itself, Delta Dental must provide notice to you.

Delta Dental may change the rates and/or benefits under this policy on this policy's renewal date. Delta Dental will send you notice of a rate change at least 60 days before the change takes effective.

This policy is valid for 12 months. When you buy this policy, you are committing to keeping it in force for at least 12 months, starting with the policy's effective date. After that, you can renew this policy for another 12 month period under the following circumstances: if we agree, if you remain eligible, and if premiums are paid according to the procedure described above.

DEFINITIONS

ADVERSE DETERMINATION means a denial of: A preauthorization for a covered benefit; a request for benefits for an individual on the grounds that the treatment or covered benefit is not medically necessary, appropriate, effective, or efficient or is not provided in or at the appropriate health care setting or level of care; a request for benefits on the ground that treatment or service is experimental or investigational; or a benefit denied because the treatment is an excluded benefit and wherein the claimant presents evidence from a dental professional licensed pursuant to the Dental Practice Law of Colorado that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit.

ALTERNATE BENEFIT means the benefit allowed for the least costly, commonly accepted Service or supply that could be used to treat a dental problem for which there are other, more costly treatment options that the covered person selects.

BENEFITS mean those Services and supplies covered pursuant to the terms of this plan. Benefits for all Covered Services are subject to the limitations and exclusions noted in this Benefit Booklet.

CLEAN CLAIM means a claim for payment of health care expenses that is submitted to Delta Dental on the uniform claim form adopted by the American Dental Association with all required fields completed with correct and complete information, including all required documents. It does not include a claim from a provider who is under review for fraud or abuse, a claim under review as medically necessary, or a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

COINSURANCE means the percentage of a Covered Amount which is payable by Delta Dental. The Coinsurance for each type of Covered Service is shown on the Schedule of Benefits. The Coinsurance applicable will vary depending upon the type of dental Service.

COMPLETED means:

- For Root Canal Therapy: The date the canals are permanently filled.
- For Fixed bridges (fixed partial dentures), Crowns, and other laboratory prepared restorations: On the date the restoration is cemented in place, regardless of the type of cement used.
- For Dentures and Partial Dentures (removable partial dentures): On the date that the final appliance is first inserted in the mouth.
- For all other Services, on the date the procedure is Completed.

For claim payment purposes, the date Completed will be the date when a claim is incurred.

DEDUCTIBLE means the amount that must be paid by the covered person before Delta Dental will make payment. The amount of the Deductible is shown on the Schedule of Benefits. If there is a limit to the deductible amount that a family must pay, that will also be shown.

DENTAL INJURY is an injury to a Sound Natural Tooth (other than a chewing injury) of a Covered person which results solely from a sudden, unexpected violent act or

accident. A chewing injury is any injury that occurs from biting or chewing food or a foreign object.

DEPENDENT means:

- The Subscriber's lawful spouse, including, civil union partner, or domestic partner.
- Civil Union partner must meet each of the requirements listed below:
  - ❖ They must be at least 18 years old.
  - ❖ They must be of the same or opposite sex.
  - ❖ They must not be a partner in another civil union.
  - ❖ They must not be married to another person.
  - ❖ They must not be related.
  - ❖ They must have entered into a civil union based on the guidelines of Article 15 of Title 14, C.R.S. recognized pursuant to Colorado Law.
- Domestic partner must meet each of the requirements listed below:
  - ❖ They must be at least 18 years old and view themselves as a family.
  - ❖ They must be of the same or opposite sex.
  - ❖ They must not be married and may not have another partner.
  - ❖ They must have lived together for at least 6 consecutive months.
  - ❖ They must not be related.
  - ❖ They must be financially interdependent.
- A child under the Dependent Age Limit shown on the Schedule of Benefits.
- A child who reaches the Dependent Age Limit stated on the Schedule of Benefits and is incapable of self-support because of physical or mental disabilities that began before reaching the Dependent Age Limit, and is dependent on the Subscriber. Delta Dental may annually request proof of such disability and dependency. Failure to submit such proof will terminate coverage.

Eligible children include natural children, stepchildren, children under court-ordered guardianship, adopted children, foster children, and children of civil union or domestic partner.

No one may be covered as a Dependent and also as a Subscriber under this plan. If both parents are covered as Subscribers, children may be covered as Dependents of one parent only.

Persons in active military service are not eligible Dependents.

EFFECTIVE DATE is the date coverage begins.

EMERGENCY TREATMENT or EMERGENCY SERVICE means any required Service that is provided as the direct result of an unforeseen occurrence that requires immediate, urgent action.

ESSENTIAL HEALTH BENEFIT means the Affordable Care Act lists pediatric services, including dental care, as one of the ten essential health benefits (EHB) that must be included in most insurance plans starting in 2014.

EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES means those services or supplies that are not generally accepted in the dental community as being safe and effective, as defined by Delta Dental.

FUNCTIONING NATURAL TOOTH means an adult Natural Tooth which performs its normal role in chewing in the upper or lower arch and is opposed in the other arch by another Natural or artificial Tooth. Third molars are not Functioning Natural Teeth.

MAXIMUM PLAN ALLOWANCE means the maximum allowable amount for a procedure as determined by Delta Dental.

MEDICALLY NECESSARY ORTHODONTIC SERVICES is care that is directly related to and an integral part of the medical and surgical correction of a functional impairment resulting from a congenital defect or anomaly. Orthodontics may be considered medically necessary in congenital defects or anomalies when they correct dentoalveolar arch discrepancies, the correction of which is necessary to satisfactorily correct other aspects of the general deformity that results in a functional impairment, or to prevent relapse of such treatment. The following are examples of congenital defects or anomalies that affect the face and possibly the dentoalveolar arches or their relationships to each other and may be medically necessary depending on the functional impairment: Hemifacial microsomia; Crouzon's syndrome; Apert syndrome.

NATURAL TOOTH means any tooth or part of a tooth that is organic and formed by the natural development of the body (i.e., not manufactured). Organic portions of a tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp (nerve).

NECESSARY means a Service that is required by, and appropriate for treatment of, the Covered person's dental condition according to generally accepted standards of dental care as determined by Delta Dental.

POLICY means the agreement between Delta Dental and the subscriber. This Policy is the whole agreement between the parties and no change is allowed unless approved by the insurer.

POLICY TERM means the time from the Effective Date of the Policy until it is terminated.

POLICY YEAR is the 365 days beginning on the Effective Date of this Policy, and each year after unless the Policy is terminated. The Policy Year is 366 days in a leap year.

PROVIDER means a person licensed to practice dentistry.

SOUND NATURAL TOOTH means a Natural Tooth that is fully restored to function, does not have any decay, is not more subject to injury than a virgin tooth, and is without periodontal disease.

STARTED means:

- For Full Dentures or Partial Dentures (removable partial dentures): The date the final impression is taken.
- For Fixed bridges (fixed partial dentures), Crowns, and other laboratory prepared restorations: The date the teeth are first prepared (i.e., drilled down) to receive the restoration.
- For Root Canal Therapy: The date the pulp chamber is first opened.
- For Periodontal Surgery: The date the surgery is actually performed.
- For All Other Services: The date the Service is performed.

SUBSCRIBER means the person in whose name the membership under the policy is established.

WAITING PERIOD means a period of time starting on a covered person's Effective Date (the date that Person's coverage under the plan began) before Benefits for certain Services become payable. If a Covered Service is Completed before the Waiting Period for the Service ends, that Service is not covered under the Plan. If a Person's Coverage under this plan ended and then the Person later becomes covered again, that Person's Effective Date is the most recent Effective Date unless stated otherwise in the Plan.

Any waiting periods will be waived for you if you were covered under another comprehensive dental insurance plan for at least 12 months before you enrolled in this plan, but only if there was no more than a 63-day gap between your previous plan and this plan. (You may have to supply information about your previous plan to make sure you qualify for waived waiting periods.) Waiting periods will not be waived for new subscribers added to this policy, unless they were covered under another comprehensive dental insurance plan for at least 12 months before they enrolled in this plan, and if there was no more than a 63-day gap between their previous plan and this plan. **If Waiting Periods are applicable to coverage, they are noted on the Schedule of Benefits.**