GROUP DENTAL PLAN
BENEFIT BOOKLET

FOR

UNIVERSITY OF COLORADO
and AFFILIATE

University of Colorado #6042
University Physicians, Inc. #1650

PPO PROGRAM

Effective: July 1, 2014

DELTA DENTAL®

Delta Dental PPO
Schedule of Benefits
UNIVERSITY OF COLORADO and AFFILIATE

This Schedule of Benefits should be read in conjunction with your Employee Benefit Booklet. Your Employee Benefit Booklet will provide you with additional information about your Delta Dental plan, including information about plan exclusions and limitations. **In the event that you seek treatment from a non-participating dentist, you may have more out-of-pocket costs.**

Control Plan - Delta Dental of Colorado
Plan Year - July 1st to June 30th

	PPO Dentist	Delta Dental Premier Dentist	*Non-Participating Dentist
Covered Services	**Plan Pays**	**Plan Pays**	**Plan Pays**
Diagnostic, Preventive & Adjunctive Services			
Sealants	100%	100%	100%
Oral Exams and Cleanings	100%	100%	100%
X-Rays	100%	100%	100%
Fluoride Treatment	100%	100%	100%
Basic Restorative Services			
Basic Restorative (Fillings)	80%	60%	60%
All Other Basic Services			
Simple Extractions	70%	50%	50%
Complex Oral Surgery	70%	50%	50%
Endodontics (Root Canal Therapy)	70%	50%	50%
Periodontics (Gum Disease Treatment)	70%	50%	50%
Major Services			
Denture Repair/Relines/Rebases	50%	40%	40%
Prosthodontics (Dentures, Bridges)	50%	40%	40%
Special Restorative (Crowns, Implants, & Onlays)	50%	40%	40%
Orthodontic Services			
Orthodontics (child to age 19)	50%	40%	40%

*** Important: Non-Participating Dentists 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 Dentist.**

Age

Type	Age Limit	Coverage Thru
Dependent Child	27	Month
End Dependent Ortho	19	Month

Deductible (July 1st - June 30th)

Class	Type	Network	Amt
All Covered Classes Except Diagnostic &Preventive and Ortho	Individual coverage amount	Premier or Non-PPO	$75
All Covered Classes Except Diagnostic &Preventive and Ortho	Individual coverage amount	PPO	$50

If a patient received services from a PPO dentist and also from a Non-PPO Dentist a separate deductible applies for each type of Provider.

Maximum (July 1st - June 30th)

Class	Type	Network	Amt
All Covered Classes Except Ortho	Individual coverage amount	PPO, Premier or Non-PPO	$2000
Orthodontic Classes	Individual lifetime	PPO, Premier or Non-PPO	$1500

Enrollment Type

Open Enrollment. Open enrollment means a period of time occurring prior to July 1st during which eligible Employees may choose to enroll themselves and/or their eligible Dependents in the Plan, or change from one coverage option to another. Coverage will become effective on July 1st .

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

PPO Participating Dentist

Advantages of seeing a PPO Dentist include:

- Payment is based upon the PPO Dentist's Allowable fee, or the fee actually charged, whichever is less.
- 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 Dentist.

Premier Participating Dentist (Non-PPO)

You have the option of seeing a Premier Dentist, 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 Dentists.
- You are only responsible for any applicable deductible and coinsurance for covered procedures.

Non-Participating Dentist (Non-PPO)

You have the option of seeing a non-participating Dentist, but you may incur additional out-of-pocket costs.

- You may be responsible for payment in full to the Dentist 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 Dentist.

COVERED AMOUNT means

- For PPO Dentists, the lesser of the PPO Dentist's Allowable fee or the fee actually charged.
- For Premier Participating Dentists, the lesser of the Premier Maximum Plan Allowance, or the fee actually charged.
- For all other Dentists, the lesser of the Non-Participating Maximum Plan Allowance, or the fee actually charged.

Colorado counties without PPO or Premier Providers are Bent, Conejos, Costilla, Crowley, Dolores, Gilpin, Hinsdale, Jackson, Kiowa, Mineral, Rio Blanco, Saguache, San Juan, and Sedgwick.

Delta Dental of Colorado
Group Dental Plan for University of Colorado and Affiliate

CONTACT US

Visit Delta Dental's Website at:
www.deltadentalco.com

You can search for a Dentist, download a claim form or access other personal account information.

Delta Dental of Colorado
4582 South Ulster Street, Suite 800
Denver, CO 80237

Customer Service:
1-800-610-0201

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ELIGIBILITY

All individuals eligible to become Subscribers and Dependents under this plan as described below shall be covered on the effective date. Subscribers and Dependents shall become eligible pursuant to the terms set forth below, as interpreted and determined by the University of Colorado. All retirees will become eligible as determined by the University of Colorado.

SUBSCRIBER

The Subscriber is a Member in whose name the membership is established. An employee must contact the employer for eligibility requirements.

DEPENDENTS

A Subscriber's Dependents (except a Regent Board member's dependents are not eligible for the Plan) may include the following:

- **Spouse.** Contact your employer for eligibility requirements. All references in this Benefit Booklet to a spouse shall include a **Common-Law Spouse, partner in a civil union, or Same Gender Domestic Partner (SGDP),** except that a civil union partner or SGDP is not eligible for COBRA coverage. A civil union partner or SGDP and their children are eligible through the employer for continuation coverage under the same time conditions and periods as COBRA.
- **Newborn child**. A newborn child born to the Subscriber or Subscriber's Spouse is covered under the Subscriber's membership for the first 31 days after birth. If the mother of the newborn child is a Dependent child of the Subscriber, the newborn is not provided benefits (see the Grandchild heading in this section). During the first 31–day period after birth, benefits for a newborn child shall consist of Medically Necessary care for injury and sickness, including well child care and treatment of medically diagnosed Congenital Defects and Birth Abnormalities, without regard to the limitations and exclusions applicable to other conditions or procedures or services covered under this Benefits Booklet. All services provided during the first 31 days of coverage are subject to the cost-sharing requirements and any benefit maximums applicable to Services otherwise covered. To continue the newborn child's participation in the coverage beyond the 31-day period after the newborn child's birth, the Subscriber must complete and submit a Benefits Enrollment/Change Form to add the newborn child as a Dependent child to the Subscriber's policy. The employer must receive the Benefits Enrollment/Change Form within 31 days after the birth of the child to continue coverage for the 32nd day and thereafter. For example: the newborn child is born on January 15th, you have 31 days from the birth to notify the employer of the newborn's birth. If the current coverage is a single only policy and the child is to continue coverage beyond 31 days, the effective date of coverage for the newborn child is on the date of birth and the change in the premium payment is effective on February 1st.
- **Adopted child**. An unmarried child (who has not reached 18 years of age on the date of placement for adoption) adopted while the Subscriber or the Subscriber's Spouse is eligible for benefits will be covered for 31 days after the date of placement for adoption. As used in this section, "Placement for adoption" means the point in time at which a Subscriber assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement terminates when the legal obligation for support terminates. To continue the adopted child's participation in the Plan beyond the 31-day period after the adopted child's placement, the Subscriber must complete and submit a Benefits Enrollment/Change Form to add the adopted child as a Dependent child to the Subscriber's benefit Plan. The employer must receive the Benefits Enrollment/Change Form within 31 days after the placement of the child for adoption to continue coverage for the 32nd day and thereafter. For example: the placement of the adopted child is on January 15th, you have 31 days from the placement to notify the employer of the adoption. If the current coverage is a single only policy and the child is to continue coverage beyond 31 days, the effective date of coverage for the adopted child is on the date of placement and the change in the premium payment is effective on February 1st.
- **Dependent child.** A Subscriber's son, daughter, stepson, stepdaughter or eligible foster child, including a legally adopted individual or an individual who is lawfully placed with the Subscriber for legal adoption, or a child for whom the Subscriber has established parental responsibility (as evidenced by court documents), or a son or daughter of a Subscriber's partner in a civil union or SGDP, including a legally adopted individual or an individual who is lawfully placed with the Subscriber's partner in a civil union or SGDP for legal adoption, or a child for whom the Subscriber's partner in a civil union or SGDP has established parental responsibility (as evidenced by court documents), may be covered under the terms of this Benefits Booklet through the end of the calendar month in which the child turns 27. There may be tax consequences to the Subscriber when enrolling his or her child through the calendar month in which the child turns age 27. There may also be tax consequences to the Subscriber when enrolling the child of his or her civil union partner or SGDP. A Dependent child of a Subscriber who is no longer eligible for coverage may be eligible for continuation coverage. Information can be found under the heading **Continuation of Benefits** in this section of this Benefits Booklet. The dependents (spouse or child) of a Dependent child are not eligible for coverage under this Benefits Booklet.

- **Disabled Dependent child.** An unmarried child who is 27 years of age or older, medically certified as disabled, and dependent upon the parent may be covered under the terms of this Benefits Booklet. The employer must receive notice of the disability for the disabled Dependent coverage to continue after the Dependent child turns age 27.
- **Grandchild.** A grandchild of a Subscriber or a Subscriber's Spouse is not eligible for benefits unless the Subscriber or the Subscriber's Spouse is court-appointed as having parental responsibility for the grandchild or has adopted the grandchild. The Subscriber must submit a Benefits Enrollment/Change Form and evidence of court appointment as having parental responsibility or documents evidencing a legal adoption.

DEPENDENT ELIGIBILITY

Eligible dependents may be enrolled within 31 days of any of the following:

- Eligible dependents may be enrolled at the time the Employee first becomes eligible for the plan. The effective date will be that of the Employee.
- New dependents must be enrolled within 31 days and will be covered the first of the following month. Newborns and adopted children will be covered on the date of birth or date of placement for adoption.
- Eligible dependents who lose coverage through another source will be allowed to enroll within 31 days of the loss of coverage with proof of loss.

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

How to Find a Dentist

There are two easy ways to find out if your Dentist is participating with Delta Dental.

1. **Visit our website at www.deltadentalco.com or**
2. **Phone our automated call center** at 1-800-610-0201

The Delta Dental network is subject to change. Please check on the participating status of your Dentist before your next appointment.

BENEFITS/COVERAGE (What Is Covered)

COVERED DENTAL SERVICES

DIAGNOSTIC & PREVENTIVE SERVICES

Diagnostic: Certain Services performed to assist the Dentist in evaluating the existing conditions and determining the dental care required.

Preventive: Certain Services performed to prevent the occurrence of dental abnormalities or disease.

Adjunctive: Certain additional Services, including emergency palliative treatment, performed as a temporary measure that does not affect a definitive cure.

PROCEDURE	BENEFIT DESCRIPTION
Oral Exam (All exam types)	Two exams in a plan year are covered. There is no separate benefit for diagnosis, treatment planning or consultation by the treating dentist.
Dental Cleaning	Two cleanings in a plan year are covered. An adult cleaning is not covered for persons under age 14. For those with any condition(s) listed below, 2 additional cleanings (or any procedure that includes cleaning) will be provided during a 12 month period. • Diabetes with documented gum conditions, • Pregnancy with documented gum conditions, • Cardiovascular disease with documented gum conditions, • Kidney failure with dialysis and • Suppressed immune system due to chemotherapy or radiation treatment, HIV Positive status, Organ Transplant or stem cell (bone marrow) transplant.
Bitewing x-rays	Covered two times in a plan year.
Full Mouth Survey or Panoramic x-ray	Covered one time in a 36 month period under any Delta Dental plan unless documentation of special need is provided.
Individual Periapical x-rays Intraoral Occlusal x-rays Extraoral x-rays	Limited to the allowance for a full mouth survey or panoramic x-ray. If the fee meets or exceeds the allowance for a complete mouth survey, it will be processed as a complete mouth survey.

Sealants	Covered one time per tooth in a 36 month period. Allowed for the occlusal (chewing) surface of decay-free unrestored permanent molars. Covered for children under the age of 16. There is no separate benefit for preparation of the tooth or any other procedure associated with the sealant application.
Preventive Resin Restoration	Covered as a sealant above.
Fluoride Treatment	Covered two times in a 12 month period. Covered for children under the age of 16.
Space Maintainer	Covered for children under the age of 16 to maintain space left by prematurely lost baby back teeth.
Adjunctive Services	Services related to another category of covered services will be covered at the same percentage as the related category of covered services.
Palliative Treatment	Covered as a separate benefit only if no other service is provided during the visit except an exam and/or x-rays.

BASIC SERVICES

Basic Restorative: Fillings and preformed shell crowns, for treatment of tooth decay which results in visible destruction of hard tooth structure or loss of tooth structure due to fracture.

Oral Surgery: Extractions and certain other surgical Services and associated covered anesthesia and/or related Covered Services.

Endodontic: Certain Services for treatment of non-vital tooth pulp resulting from disease or trauma.

Periodontic: Certain Services for treatment of gum tissue and bone supporting teeth.

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 12 months have 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 12 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.
Stainless Steel Crowns, Resin Crowns	Covered when the tooth cannot be restored by a filling and then 1 time in a 36 month period.
Oral Pathology Lab Procedures	Covered with a pathology report.
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.
Pin Retention	Covered with a basic (amalgam or composite) filling. A benefit one time per filling.
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.
Therapeutic Pulpotomy	Covered for baby teeth only.
Root Canal Therapy	Covered once per tooth. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Repeat Root Canal therapy	Covered only if the first root canal procedure was performed at least 24 months earlier.
Apexification/recalcification (apical closure/calcific repair of perforations, root resorption, etc.)	Covered once per tooth. A course of treatment includes initial, interim and final visits. 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)	Covered once per root each 24 months. 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.
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	Periodontal maintenance procedures or any combination of periodontal maintenance procedures and prophylaxis (adult and child cleanings), are limited to 4 per any 12 month period.
Gingivectomy	One periodontal surgical procedure is covered per quadrant in any 36 month period. 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	One periodontal surgical procedure is covered per quadrant in any 36 month period. 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)	One periodontal surgical procedure is covered per quadrant in any 36 month period. 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.
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 allowed as benefits.
General Anesthesia	Allowed as a separate benefit when provided for covered oral surgical procedures. One type of anesthesia procedure per date of service.
Analgesia (Nitrous oxide)	Allowed as a separate benefit when provided for covered oral surgical procedures. One type of anesthesia procedure per date of service.
I.V. Sedation	Allowed as a separate benefit when provided for covered oral surgical procedures. One type of anesthesia procedure per date of service.

MAJOR SERVICES

Special Restorative: Buildups (which may or may not include a post) and laboratory processed restorations (crowns, onlays) for treatment of tooth decay which results in visible destruction of hard tooth structure, or loss of tooth structure due to fracture, which cannot be restored with amalgam or composite restorations.

Prosthodontics: Services for construction or repair of fixed partial dentures (bridges), cast or acrylic removable partial dentures, acrylic complete dentures, and removable temporary partial dentures to replace completely extracted or avulsed natural permanent teeth.

PROCEDURE	BENEFIT DESCRIPTION
Re-Cement crowns, Inlays and Onlays	Covered after 6 months from initial insertion.
Repairs to Crowns	Subject to Delta Dental's consultant review.
Re-Cement Fixed Bridges	Covered after 6 months from initial insertion of fixed bridge.
Repairs to Fixed Bridges	Subject to Delta Dental's consultant review.
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	Covered two times in a 36 month period.
Relining Dentures **Rebasing Dentures**	Relining or rebasing 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 36 month period per appliance.
Inlays	An alternate benefit allowance for an amalgam filling will be made for the same number of surfaces. Any difference in fee is chargeable to the patient. It will be covered if 60 months have passed since the last placement. Not covered for children under age 12.

Crowns & Onlays	Covered when the tooth cannot be restored by an amalgam or composite filling and if more than 60 months since the last placement. Not covered for children under age 12.
Core (Crown) Buildup including any pins	Covered once in 60 months per tooth when needed to retain a crown or onlay and only when need is due to extensive loss of tooth structure caused by decay or fracture. Not covered for children under age 12.
Post and Core (in conjunction with a Crown or Onlay)	Covered once in 60 months per tooth for endodontically treated teeth. Must be needed to retain a crown or onlay, and when necessary due to extensive loss of tooth structure caused by decay or fracture. Not covered for children under age 12.
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 60 months for restorations involving the same tooth. This limitation includes any prior Special Restorative or Prosthodontic benefits for the same tooth. Not covered for children under age 16.
Fixed Bridges	Initial fixed bridge is covered. Replacement of an existing fixed bridge is covered if the existing fixed bridge is more than 60 months old, is not serviceable, and cannot be repaired. Not covered for children under age 16.
Core (Bridge) Buildup including any pins (in conjunction with a Bridge Abutment)	Covered once in 60 months per tooth when needed to retain a fixed bridge and only when needed due to extensive loss of tooth structure caused by decay or fracture. Not covered for children under age 16.
Post and Core (in conjunction with a fixed bridge)	Covered once in 60 months 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. Not covered for children under age 16.
Full Dentures	Initial full dentures are covered. Replacement is covered after 60 months from the last placement. Dentures must not be able to be repaired. Personalized dentures, overdentures or associated procedures are not covered.
Partial Dentures	Initial partial dentures are covered. Replacement is covered after 60 months have elapsed since the last placement. Dentures must not be able to be repaired. Precision or semi-precision attachments are not covered. The benefit for a partial denture includes any clasps and rests and all teeth. Not covered for anyone under age 16.
Temporary Removable Partial Dentures	Initial temporary removable partial dentures are covered to replace missing permanent front teeth. Replacement is covered only after 60 months have elapsed since the last placement.

ORTHODONTIC SERVICES

PROCEDURE	**BENEFIT DESCRIPTION**
Orthodontic Treatment	Orthodontics are defined as the services provided by a licensed Dentist involving orthognathic surgery or appliance therapy for movement of teeth and post-treatment retention for treatment of malalignment of teeth and/or jaws including any related interceptive services.
Limitations on Orthodontic Benefits	a) No benefits will be provided for: • Replacement or repair of appliances. • Orthodontic care provided in the treatment of periodontal cases or cases involving treatment or repositioning of the temporomandibular joint or related conditions. b) Periodic Orthodontic payments will end upon termination of treatment for any reason prior to completion of the case, or upon termination of the Covered Person's eligibility. c) For an Orthodontic treatment plan started prior to the eligibility date of the patient, Delta Dental will begin periodic payments with the first payment due following the patient eligibility date. The maximum benefit will be determined based upon the prior carrier's payment history.

LIMITATIONS/EXCLUSIONS
(What Is Not Covered)

GENERAL LIMITATIONS – ALL SERVICES

a. Alternate Benefits - Often more than one service or supply can be used to treat a dental problem. In deciding the amount allowed on a claim, other materials and methods of treatment will be considered. 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 Dentist may decide on a more costly procedure or material. 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.

b. The benefit allowed for a temporary service and the final service is limited to the benefit allowed for the final dental service, unless the temporary service is specifically included as a Covered Service of the Contract.

c. Dental procedures performed at the same time and as part of a primary procedure will be paid at the amount allowed for the primary procedure.

d. Completed dental Services are covered when provided by a Dentist (or other person legally permitted to perform such Services by authority of license) and are determined under the standards of generally accepted dental practice to be Necessary and appropriate. Benefits will be determined (even if no monies are paid) based on the terms of the Contract and Delta Dental's Processing Guidelines.

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.

EXCLUSIONS

a) Services for injuries or conditions which are covered under Worker's Compensation or employer's liability policies. Services which are provided by any federal or state government agency. Services that are provided without cost by any city, county or other political subdivision. Any Services for which the person would not have to pay if not insured, except if such exclusion may be prohibited by law.

b) Any Service Started when the person was not covered under this Contract. This includes any Service Started during an applicable Waiting Period.

c) Services for treatment of congenital (present at birth) or developmental (following birth) defects, except dental Services within the mouth for treatment of a condition related to or resulting from cleft lip and/or cleft palate. This exclusion does not apply if otherwise covered under this contract.

d) Any procedure, service or supply 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 Dentist's approved fee.

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

f) Services related to protecting, altering, correcting, stabilizing, rebuilding, or maintaining teeth due to improper alignment, occlusion or contour.

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

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

i) Pre-medication, analgesia, hypnosis or any other patient management services (except covered anesthetic services).

j) Charges for prescribed drugs.

k) Any Experimental or Investigational Procedures.

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

m) Any procedures 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 of tissues or other substances from outside the mouth into the mouth. Augmentations and any associated appliances.

r) Myofunctional therapy or speech therapy.

s) Services for the treatment of any temporomandibular joint (TMJ) problems, including facial pain, or any related conditions. Includes any related diagnostic, preventive or treatment Services.

t) Services not performed in accordance with the laws of the State of Colorado. Services performed by any person other than a person licensed to perform such Services. Services performed to treat any condition, other than an oral or dental disease, malformation, abnormality or condition.

u) Teaching in oral hygiene or diet planning.

v) Completion of forms. Providing diagnostic information or records. Copying of x-rays or other records.

w) Replacement of lost, stolen or damaged appliances.

x) Repair of appliances altered by someone other than a Dentist.
y) Any Services not included in Covered Services.
z) Services for which charges would not have been made if this coverage had not existed, except for Services as provided under Medicaid.
aa) Missed appointment charges.
bb) Preventive control programs, including home care items.
cc) Plaque control programs.
dd) Injuries you cause yourself.
ee) Provisional splinting.
ff) Bone grafting when done in the same site as a tooth extraction, implant, apicoectomy or hemisection.
gg) Services provided for treatment of teeth retained in relation to an Overdenture.
hh) Any Prosthodontic service provided within 60 months of Special Restorative services involving the same teeth.
ii) Any Special Restorative service provided within 60 months of fixed Prosthodontic services involving the same teeth.
jj) Fixed and removable Prosthodontic appliances (bridges and partials) are not a benefit in the same arch except when the fixed denture (bridge) replaces front teeth. Allowance is limited to the allowance for the removable partial denture.

MEMBER PAYMENT RESPONSIBILITY

Some things that may affect the amount you will pay include your specific plan and if your dentist participates (and at what level) with Delta Dental.

You are responsible for deductibles, amounts above the maximum allowed, and your coinsurance. You must pay charges for Services not covered under this contract. You may be responsible for some part of the premium.

CLAIM PROCEDURES (How to File a Claim)

If your Dentist participates with Delta Dental, the claim form will be filed by your Dentist. The patient must sign the form to permit release of the information to Delta Dental.

If you elect treatment from a Dentist who does not participate with Delta Dental, you may need to file your own claim.

If you are covered by more than one dental plan, you should file all of your claims with each plan.

Delta Dental will not pay claims submitted more than 12 months after the date the service was provided.

PRE-TREATMENT ESTIMATE

Before starting dental treatment that may cost $400 or more, you may request an estimate from Delta Dental of what is covered. Pre-treatment estimates are not required and are provided as a service to the covered person and Dentist.

GENERAL POLICY PROVISIONS

COORDINATION OF BENEFITS

Coordination of Benefits means taking other Plans into account when paying Benefits. Coordination of Benefits will apply when a covered person is covered under more than one Plan. The Benefits of this Plan will be coordinated with the other Plan(s).

Plan: A Plan that pays or provides for dental services on a group or individual basis. This includes group and blanket insurance, self-insured and prepaid plans, automobile insurance and government plans (except Medicaid).

Primary Coverage: The plan that must pay first. The Primary Coverage must pay up to its full liability.

Secondary Coverage: The plan that must pay a claim after the Primary Coverage has paid its part.

The rules for the order of benefit payment are summarized below.

- The Plan provided to a covered person as an Employee will be primary to a policy on which the covered person is a dependent.
- For dependent children, primary and secondary coverage will be determined as follows.
  - ❖ The Plan of the parent whose birthday occurs earlier in the year will be primary, or;
  - ❖ If the parents are separated or divorced, the Plan of the parent who is ordered by court decree to pay for dental expenses will be primary, or;
  - ❖ The Plan of the parent with custody is Primary and if the custodial parent has remarried, the step-parent's Plan is Secondary and the Plan of the parent without custody pays third.
- If the above rules do not establish an order of benefit payment, the Plan that has covered the Person the longest will be Primary. If that Plan covers someone who has been laid off or is retired it will be Secondary to any other Plan.
- A group Plan that does not contain a Coordination of Benefits clause is primary.

If this Plan is Primary, we will pay claims without regard to benefits provided by any other Plan. If this Plan is Secondary, we will pay claims so that together with the other Plan payment will not exceed 100% of the allowable expense or this Plan's maximum benefit.

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, your employer has agreed to:

a) Not use or further disclose health information protected under HIPAA 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 that apply to your employer.
c) Not use or disclose PHI for employment related 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 Plan and the Plan Sponsor 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 group health plan.
j) Ensure that any agent to whom it provides electronic PHI agrees to implement security measures to protect the information.
k) Report to the group health plan any security incident of which it becomes aware.

DELTA DENTAL OF COLORADO—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 group 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 dentist 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 dentists 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.

Disclosure to Plan Sponsors: For example, to help the sponsor of your group health plan administer your benefits.

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

TERMINATION/ NONRENEWAL/CONTINUATION

Coverage will terminate at the earliest of:

- The last day of the month Delta Dental receives a written request to cancel coverage;
- The last day of the month in which you become ineligible for coverage;
- The date the Contract terminates;
- The end of the period for which Premium is paid;
- The date a covered person enters full-time military service of any country; or
- As to any Dependent, the date the person no longer qualifies as a Dependent. Loss of Dependent status can occur for many different reasons. Your employer may not know when this happens. Therefore, you are required to notify your employer within 31 days of the event or the loss of coverage.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

Covered persons may be able to continue coverage through COBRA. The benefits will be the same as the benefits active Employees receive. The Covered person must pay the entire Premium, which cannot exceed 102% of the cost for an active employee with the same Plan. You should contact your employer to determine if you are able to continue coverage through COBRA.

Continued Health Coverage required by the State of Colorado

If you are not eligible for COBRA you may be eligible to continue coverage for up to 18 months under State Continuation. Contact your employer to learn if you are eligible to continue coverage through state continuation.

Continuation Health Coverage Through Employer

Covered persons not eligible for COBRA may be eligible for continuation coverage through the Subscriber's employer. The benefits will be provided under the same time conditions and time periods as COBRA.

EXTENDED COVERAGE

Delta Dental benefits will end if this Contract is terminated or if your coverage is cancelled. Delta Dental will cover no further care or Services with the exception explained below.

If a Covered Service was Started before cancellation, but the Covered Service is Completed after Delta Dental cancellation, 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 and conditions of the Contract that would have applied, if the Person's coverage was still in effect.
- Benefits are payable 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.

APPEALS AND COMPLAINTS

A covered person may appeal an adverse decision made on a claim. An appeal request must be submitted in writing within 180 days of the date of the original Explanation of Benefits to:

Delta Dental of Colorado
Appeals Analyst
PO BOX 172528
Denver, CO 80217-2528

A covered person may submit new information in support of the appeal. If an appeal is denied, a second-level or external appeal may be available.

If a claim qualifies for Independent External Review, the request must be submitted in writing within 60 days of receipt of a First or Second Level Appeal denial. The request should be submitted to the Appeals Analyst at the address above. The request must include a completed External Review Request Form authorizing Delta Dental to disclose protected health information to the external reviewer.

You may make a complaint about Delta Dental services by email to Customer_service@ddpco.com. You may also write us at:

Delta Dental of Colorado
P.O. Box 172528
Denver, CO 80217-2528

INFORMATION ON POLICY AND RATE CHANGES

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 your employer and Delta Dental or due to changes to the plan itself, your employer must provide notice to you. If there are changes to the information provided in this document, we will issue revised materials to you.

DEFINITIONS

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

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, Inlays, Onlays, 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 Started.

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.

DELTA DENTAL PPO is a preferred provider plan. PPO Dentists provide services at the PPO Discounted Fee Schedule.

DENTIST means a person licensed to practice dentistry.

DEPENDENT means any individual eligible for coverage under the Subscriber's policy by virtue of his or her relationship with Employee. The various relationships that create Dependent eligibility are set forth in the Eligibility section of this Benefit Booklet.
No one may be covered as a Dependent and also as an Employee under this Contract. If both parents are covered as Employees, children may be covered as Dependents of one parent only.

Persons in active military service are not eligible Dependents.

EMPLOYEE means someone who works the minimum number of hours as defined by the employer.

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.

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

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.

PPO DENTIST'S ALLOWABLE FEE means the fee from the PPO Discounted Fee Schedule that the PPO Dentist has contractually agreed with Delta Dental to accept for treating Eligible Persons under this plan, or the fee actually charged, whichever is less, for a single procedure.

PPO PARTICIPATING DENTIST means a Dentist licensed to practice who has signed a PPO Dentist Agreement with Delta Dental of Colorado to participate in this program.

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, Inlays, Onlays 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.

Visit Delta Dental's Website at:
www.deltadentalco.com

You can search for a Dentist, download a claim form or access other personal account information.

Delta Dental of Colorado
4582 South Ulster Street, Suite 800
Denver, CO 80237-2567

Customer Service:
1-800-610-0201

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