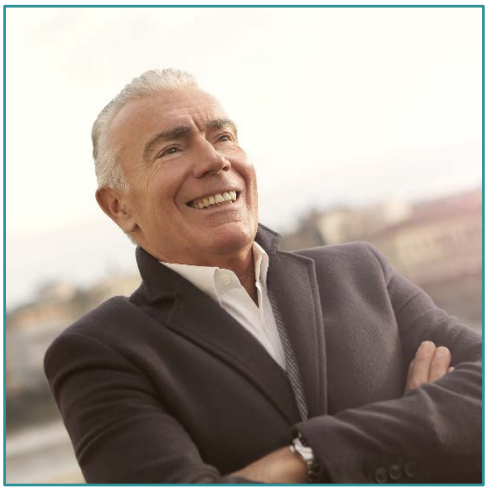
Essential Dental Benefit Booklet

Effective July 1, 2020

Group #12026









Funded by

Health Plan
University of Colorado Health and Welfare Trust

Health Plan

WELCOME

Thank you for selecting the CU Health Plan as your dental insurance provider. By choosing this plan, you're backed by a team dedicated to providing you with the best dental coverage possible and helping you save money at a time when dental healthcare costs are rising. You're committed to your oral wellness, and so are we.

If you're reading this, you're probably looking for information on how your plan works. You have enrolled in a dental health benefit plan that, pursuant to the terms of this booklet, pays for many of your dental healthcare expenses, including most expenses for preventive care, crowns, fillings and more.

This plan is self-funded by the University of Colorado Health and Welfare Trust. That means all of the claims you make will be paid by the trust, which is funded by contributions from you and other subscribers at the University of Colorado and CU Medicine. Delta Dental provides administrative services only, including provider network contracting, member services, and other administrative services.

This booklet is a guide to your plan. Please review this document, as well as your plan summary, to become familiar with your benefits, including their limitations and exclusions. By learning how your coverage works, you'll be able to make the best dental healthcare decisions possible and take advantage of all the great benefits available to you.

For questions about coverage or how benefits are administered, please visit the CU Health Plan website or call Delta's Member Services department. The toll-free Member Services department number is located on your Dental Benefit ID Card.

Thank you for selecting the CU Health Plan for your dental care needs. We wish you good health.



Tony DeCrosta
Chief Plan Administrator
University of Colorado Health and Welfare Trust

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BENEFITS/COVERAGE (What is Covered)

Delta Dental PPO
Schedule of Benefits
For Group # 12026
CU HEALTH PLAN – ESSENTIAL DENTAL

This Schedule of Benefits should be read in conjunction with your Benefit Booklet. Your Benefit Booklet will provide you with additional information about your plan, including information about plan exclusions and limitations. **Services must be provided by a Delta Dental PPO Provider. In the event services are provided by a non-PPO Provider you will be responsible for all charges incurred.**

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

	Dependent Child 0-12 Utilizing a PPO Provider	**PPO Provider**	***Delta Premier and Non-Participating Provider**
Covered Services	**Plan Pays**	**Plan Pays**	**Plan Pays**
Diagnostic & Preventive Services			
Oral Exams and Cleanings	100%	100%	NONE
X-Rays	100%	100%	NONE
Sealants	100%	100%	NONE
Fluoride Treatments	100%	100%	NONE
Basic Services			
Basic Restorative (Fillings)	100%	70%	NONE
Oral Surgery	100%	70%	NONE
Endodontics (Root Canal Therapy)	100%	70%	NONE
Periodontics (Gum Disease Treatment)	100%	70%	NONE
Major Services			
Special Restorative (Crowns, Onlays)	100%	50%	NONE
Prosthodontics (Dentures, Bridges)	N/A	50%	NONE
Implant Services	N/A	50%	NONE
Orthodontic Services			
Orthodontics (Child to age 19)	50%	50%	NONE

*** Important: If you do not use a Delta Dental PPO Provider, you will be responsible for all charges incurred.**

Age

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

Deductible (July 1st to June 30th)

Class	Type	Network	Amount
All Covered Classes Except D&P and Ortho Age 13 and Older	Individual coverage amount	PPO	$25

Maximum (July 1st- June 30th)

Class	Type	Network	Amount
All Covered Classes Except D&P and Ortho	Individual coverage amount	PPO	$2000
Orthodontic Classes	Individual lifetime	PPO	$2000

Under the CU Health Plan- Essential Dental plan, all services must be provided by a PPO Participating Provider. In the event services are provided by a non-PPO Participating Provider, the subscriber or dependent will be responsible for all charges incurred.

- Payment is based upon the PPO Provider's Allowable fee, or the fee actually charged, whichever is less.
- You are responsible for any applicable coinsurance for covered procedures.
- Claim forms are submitted directly to Delta Dental by the Providers.
- No balance billing.
- Payment is made directly to the Provider.

No Payment will be made for Services provided by a Provider who is not a PPO Provider.

Welcome to your dental CU Health Plan, funded by the University of Colorado Health and Welfare Trust, where it's our mission to mitigate the rising costs of healthcare, tailor plans to the specific needs of Subscribers, retirees and their dependents based on data and evidence-based approaches, and emphasize a commitment to wellness.

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 your employer. All retirees will become eligible as determined by your employer.

DEPENDENT ELIGIBILITY

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

- Eligible dependents may be enrolled at the time the Subscriber first becomes eligible for the plan. The effective date will be that of the Subscriber.
- 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

How to Find a Provider

There are two easy ways to find out if your Provider 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 Provider before your next appointment.

You are not required to obtain approval before receiving services. 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.

BENEFITS/COVERAGE (What is Covered)

COVERED DENTAL SERVICES

DIAGNOSTIC & PREVENTIVE SERVICES

Diagnostic: Certain Services performed to assist the Provider 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 provider.
Dental Cleaning	Four cleanings in a plan year are covered. Periodontal maintenance procedures or any combination of periodontal maintenance procedures and prophylaxis (adult and child cleanings) are limited to 4 per plan year. An adult cleaning is not covered for persons under age 14.
Bitewing X-rays	Covered one time in a plan year.
Full Mouth Survey or Panoramic X-ray	Covered one time in a 60 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 full mouth survey, it will be processed as a full 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 15. 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 twice in a plan year for children under the age of 17.
Silver Diamine Fluoride	Covered twice in a plan year through age 16.
Space Maintainer	Covered for children under the age 14 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.
Oral Pathology Lab Procedures	Covered with a pathology report.

Services MUST be performed by a PPO panel dentist in order to be payable under this program. Services are subject to the limitations and exclusions listed in this booklet.

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) and Composite Resin (white plastic) Fillings	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing amalgam or composite resin filling is allowed if at least 12 months have passed since the existing filling was placed.
Interim Therapeutic Restoration	Covered once per tooth per lifetime for baby teeth.
Stainless Steel Crowns **Resin Crowns**	Covered when the tooth cannot be restored by a filling and then 1 time in a 12 month period.
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.
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 if the first root canal procedure on the same tooth 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.

Services MUST be performed by a PPO panel dentist in order to be payable under this program. Services are subject to the limitations and exclusions listed in this booklet.

Periodontal Scaling and Root Planing - Per Quadrant	Covered one time per quadrant of the mouth in any 24 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 planning, 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, excision of hyperplastic gum tissue, surgical incisions, and cyst removal. Local anesthesia and routine post-operative care are not separately allowed as benefits.
General Anesthesia **Analgesia (Nitrous Oxide)** **I.V. Sedation**	Only one type of anesthesia procedure per date of service is allowed as a separate benefit when provided for covered oral surgical procedures.
Alveoloplasty	Not allowed as a separate benefit when performed on the same date as extractions. Includes local anesthesia and routine post-operative care.

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.

Implants: Prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prostheses.

Services MUST be performed by a PPO panel dentist in order to be payable under this program. Services are subject to the limitations and exclusions listed in this booklet.

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 full or partial denture.
Repairs to Full and Partial Dentures	Covered after 6 months from the insertion of the full 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 full or partial denture and then not more than one time in a 36 month period.
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 and 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 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. Covered only if 60 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 12.
Post and Core (in conjunction with a Crown or Onlay)	Covered for endodontically treated teeth. Must be needed to retain a crown or onlay, and only when necessary due to extensive loss of tooth structure caused by decay or fracture. Covered only if 60 months have passed since the last buildup or post and core procedure for the same tooth. 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, and there is no prior payment of covered special restorative or prosthodontic benefit for the same tooth. Not covered for children under age 16.
Core (Bridge) Buildup including any Pins (in conjunction with a Bridge Abutment or a Fixed Bridge)	Covered when needed to retain a fixed bridge or endodontically treated teeth. Only when necessary due to extensive loss of tooth structure caused by decay or fracture. Covered only if 60 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 16.

Services MUST be performed by a PPO panel dentist in order to be payable under this program. Services are subject to the limitations and exclusions listed in this booklet.

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. Metal based partial dentures are not covered for children 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 Provider 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) The initial orthodontic benefit payment for a comprehensive treatment plan of 13 months or more will be made in two (2) payments. The 1st payment will be issued at banding date or insertion. The 2nd payment will be issued 12 months later. The final payment will be reduced by any other orthodontic benefits issued that applied to the orthodontic plan maximum. Only members eligible in the Plan 12 months after initial banding or insertion will receive the final payment. d) The orthodontic payment benefit for treatment plans 12 months or less will be made in 1 payment at time of banding or insertion. This payment will be reduced by any other orthodontic benefits issued that applied to the plan's orthodontic maximum. e) For comprehensive orthodontic treatment in progress that began prior to eligibility in the plan, Delta Dental will reduce periodic payments using its applicable processing polices.

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, the 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.

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) The 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) Completed dental Services are covered when provided by a Provider (or 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.

i) 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 this plan and Delta Dental's Processing Guidelines, even if no monies are paid.

EXCLUSIONS

a) Services for injuries or conditions which are covered under Worker's Compensation or employer's liability laws. Services provided by any federal or state agency. Services 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, with the exception of orthodontics, when the person was not covered under this Contract. This includes any Service Started during an applicable Waiting Period. Ongoing orthodontia will be determined using the balance as of calculation.

c) 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 Provider's approved fee.

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

e) Services related to protecting, altering, correcting, stabilizing, rebuilding, or maintaining teeth due to 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 gnathological (jaw function) services, bite registration or analysis, or any related services.

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

i) Charges for prescribed drugs.

j) Any Experimental or Investigational treatment.

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

Services MUST be performed by a PPO panel dentist in order to be payable under this program. Services are subject to the limitations and exclusions listed in this booklet.

l) Any treatment done in anticipation of future need (***except*** covered preventive services).
m) Hospital costs or any charges for use of any facility.
n) Any anesthesia service not included in Covered Services.
o) Grafts done in the mouth where teeth are not present.
p) Grafts of tissues or other substances from outside the mouth into the mouth.
q) Myofunctional therapy or speech therapy.
r) 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.
s) Services not performed in accordance with the laws of the state in which the Services are provided. 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.
t) Teaching in oral hygiene or diet planning.
u) Completion of forms. Providing diagnostic information or records. Copying of x-rays or other records.
v) Replacement of lost, stolen or damaged appliances.
w) Repair of items altered by someone other than a Dentist.
x) Any Services not included in Covered Services.
y) Services for which charges would not have been if this coverage had not existed, except for Services as provided under Medicaid.
z) Missed appointment charges.
aa) Preventive control programs, including home care items.
bb) Plaque control programs.
cc) Self-injury.
dd) Provisional splinting.
ee) Bone grafting when done in the same site as a tooth extraction, implant, apicoectomy or hemisection.
ff) Services provided for treatment of teeth retained in relation to an Overdenture.
gg) Any Prosthodontic service provided within 60 months of Special Restorative services involving the same teeth.
hh) Any Special Restorative service provided within 60 months of fixed Prosthodontic services involving the same teeth.
ii) 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 PAYMENTS RESPONSIBILITY

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

You are responsible for deductibles, amounts above the maximum allowed, amounts up to the out-of-pocket maximum, 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 Provider participates with Delta Dental, the claim form will be filed by your Provider. The patient must sign the form to permit release of the information to Delta Dental.

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 of service was provided.

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 and are provided as a services to the covered person and the Provider.

Services MUST be performed by a PPO panel dentist in order to be payable under this program. Services are subject to the limitations and exclusions listed in this booklet.

GENERAL POLICY PROVISIONS

AGREEMENT WITH STATE LAW

Any requirement in this Contract which on its effective date is in conflict with the laws of the state in which any Covered Person lives is hereby changed to the minimum requirement of such laws.

COORDINATION OF BENEFITS (COB)

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 a covered person as a Subscriber 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 stepparent'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.

Questions about Coordination of Benefits?

Colorado Division of Insurance
1560 Broadway, Ste 850
Denver, CO 80202
Phone Number: 303-894-7490 or 1-800-930-3745

SUBROGATION

Delta Dental, on behalf of the CU Health Plan, 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, on behalf of the University of Colorado Health and Welfare Trust (Trust). If Delta Dental, on behalf of the Trust, 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, on behalf of the Trust, the amount equal to the benefit payment made to, or on behalf of, the covered person.

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 60 days of the event or the loss of coverage, whichever is later.

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 Subscribers receive. The Covered person must pay the entire Premium, which cannot exceed 102% of the cost for an active Subscriber 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.

EXTENDED COVERAGE

Your CU Health Plan dental benefits will end if this Contract is terminated or if your coverage is cancelled. Delta Dental, on behalf of the CU Health Plan, 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, on behalf of the Trust, 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 by writing to:

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

A covered person may submit additional 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

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

INFORMATION ON POLICY AND RATE CHANGES

If there are changes to the benefits under this plan, your employer will provide notice to you. If there are changers 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 this plan. 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, on behalf of the Trust. 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.

COVERED AMOUNT means

- For PPO Providers, the lesser of the PPO Provider's Allowable fee or the fee actually charged.

DEDUCTIBLE means the amount that must be paid by the covered person before Delta Dental will make payment, on behalf of the Trust. The amount of the Deductible is shown on the Schedule of Benefits.

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:

A Subscriber's Dependents 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 to add the newborn child as a Dependent child to the Subscriber's policy. The Employer must receive the 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.

ENROLLMENT TYPE The enrollment type is Open Enrollment. Open Enrollment means a period of time each Contract Year occurring prior to the Anniversary Date during which eligible Subscribers may choose to enroll themselves and/or their eligible Dependents in the Plan, or change from one coverage option to another if the Contract issued to the Group permits them to do so. Coverage will become effective on the Group's Anniversary Date. Where two Subscribers who are spouses and are both eligible for coverage under this contract, they may be enrolled together or separately, but not both. Dependent children may be enrolled under one parent.

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.

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.

MEMBER means any person eligible and enrolled for coverage under this plan.

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.

PROVIDER means a person licensed to practice dentistry.

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.

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

NON-DISCRIMINATION STATEMENT

The University of Colorado, as Plan Sponsor of the University of Colorado Health and Welfare Plan ("the University"), complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The University does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The University provides free aids and services to people with disabilities to communicate effectively, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). The University also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact the HIPAA Privacy Officer with CU Health Plan Administration.

If you believe that the University has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

HIPAA Privacy Officer
CU Health Plan Administration
1999 Broadway, Suite 820
Denver, CO 80203
(303) 860-4199
(303) 860-4177 (fax)
cuhealthplan@cu.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the HIPAA Privacy Officer with CU Health Plan Administration is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

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



Health Plan

1999 Broadway, Suite 820
Denver, CO 80202
303-860-4199

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

Customer Service:
1-877-FlossCU

Services MUST be performed by a PPO panel dentist in order to be payable under this program. Services are subject to the limitations and exclusions listed in this booklet.