BENEFIT BOOKLET

FOR

Health Plan
Dental EPO

CU HEALTH PLAN
Group #12026
Effective: July 1, 2015

Delta Dental PPO, Exclusive Panel Option (EPO)
Schedule of Benefits
For Group #12026
CU HEALTH PLAN

This Summary of Dental Plan 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**. Services must be provided by a Delta Dental PPO Dentist. In the event services are provided by a non-PPO Dentist you will be responsible for all charges incurred.**

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

	PPO Dentist
Covered Services	**Plan Pays**
Diagnostic & Preventive Services	
Oral Exams and Cleanings	**Co-Payment is based on Appendix A – Patient Co-Payments (EPO 6A)**
X-Rays	
Sealants	
Fluoride Treatments	
Basic Services	
Basic Restorative (Fillings)	**Co-Payment is based on Appendix A – Patient Co-Payments (EPO 6A)**
Oral Surgery	
Endodontics (Root Canal Therapy)	
Periodontics (Gum Disease Treatment)	
Major Services	
Reline and Repairs	**Co-Payment is based on Appendix A – Patient Co-Payments (EPO 6A)**
Special Restorative (Crowns, Inlays, Onlays)	
Prosthodontics (Dentures, Bridges)	
Orthodontic Services	
Orthodontics (no age limit)	**Co-Payment is based on Appendix A – Patient Co-Payments (EPO 6A)**

The orthodontic age limitations are waived for all eligible Employees, spouses and dependent children.

***Services provided by a non-PPO Participating Dentist are not a covered benefit.**

Age

Type	**Age Limit**	**Coverage Thru**
Dependent Child	27	Month

Deductible: None

Maximum (July 1st to June 30th)

Class	**Type**	**Network**	**Amount**
All Covered Classes	Individual coverage amount	PPO	$2000
Orthodontic Classes	Individual lifetime	PPO	$4000

Under the Delta Dental EPO plan, all services must be provided a Colorado PPO Participating Dentist. In the event services are provided by a non-PPO Participating Dentist, the subscriber or dependent will be responsible for all charges incurred.

- **You are only responsible for the Co-Payment amount listed on the Co-Payment Appendix sheet for Covered Services.**
- **Claim forms are submitted directly to Delta Dental by the Dentists.**
- **No balance billing.**
- **Payment is made directly to the Dentist.**

No Payment will be made for Services provided by a Dentist who is not a Colorado PPO Dentist, except for out of state emergency services.

Colorado counties without PPO Providers are Crowley, Gilpin, Jackson, Kiowa, Mineral, Pitkin, Saguache, San Juan, and Sedgwick.

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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 employees, 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.

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.

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 and are provided as a service to the covered person and Dentist.

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 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 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 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 up to one time in a plan year**.** Covered for children under the age of 16.
Space Maintainer	Covered for children under the age of 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 if no other service is performed 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
Oral Pathology Lab Procedures	Covered with a pathology report.
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.
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 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.
Alveoloplasty	Not allowed as a separate benefit when performed on the same date as extractions. Includes local anesthesia and routine post-operative care.
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 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.
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 when needed to retain a fixed bridge and only when needed 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.
Post and Core **(in conjunction with a fixed bridge)**	Covered for endodontically treated teeth. Must be needed to retain a fixed bridge, 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 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.
Benefit payments for comprehensive full-banded Orthodontic treatment are made in monthly installments. The first payment of $500.00 is due when the appliance is installed. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is insured. If insurance coverage ends or treatment ceases, payment will cease.	

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

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

d. 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.

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 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 or implants and any associated appliances. Removal of implants or any associated Services.
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 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.
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) 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 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, copayments, 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

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

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 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 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.

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 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.

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 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, your employer will 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, 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.

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. If there is a limit to the deductible amount that a family must pay, that will also be shown.

DENTAL INJURY is an injury to a Sound Natural Tooth (other than a chewing injury) of a Covered person which results solely from a sudden, unexpected violent act or accident. A chewing injury is any injury that occurs from biting or chewing food or a foreign object.

DEPENDENT means

- The Subscriber's lawful spouse, including a domestic partner. Additional supporting documentation of a domestic partner relationship may be required separately by the employer.
- A domestic partner must meet each of the requirements listed below:
  - ❖ They must be at least 18 years old and view themselves as a family.
  - ❖ They must be of the same or opposite sex.
  - ❖ They must not be married and may not have another partner.
  - ❖ They must have lived together for at least 6 consecutive months.
  - ❖ They must not be related.
  - ❖ They must be financially interdependent.
- A child under the Dependent Age Limit shown on the Schedule of Benefits.
- A child who reaches the Dependent Age Limit stated on the Schedule of Benefits and is incapable of self-support because of physical or

mental disabilities that began before reaching the Dependent Age Limit, and is dependent on the Subscriber. Delta Dental may annually request proof of such disability and dependency. Failure to submit such proof will terminate coverage.

Eligible children include natural children, stepchildren, children under court-ordered guardianship, adopted children, foster children, and children of a domestic partner**.**

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

Persons in active military service are not eligible Dependents.

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

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 Employees 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 Employees 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.

APPENDIX A - PATIENT CO-PAYMENTS (EPO 6A)

DIAGNOSTIC SERVICES

Code	Description	Co-Pay
D0120	Periodic oral evaluation	No Cost
D0140	Limited oral evaluation-problem focused	No Cost
D0145	Oral evaluation-under age 3- and counseling w/primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation-problem focused, by report	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0210	Intraoral-complete series (includes bitewings)	No Cost
D0220	Intraoral periapical x-ray 1st film	No Cost
D0230	Intraoral periapical x-ray each additional film	No Cost
D0240	Intraoral occlusal x-ray film	No Cost
D0270	Bitewing x-ray - single film	No Cost
D0272	Bitewings - 2 films	No Cost
D0273	Bitewings – 3 films	No Cost
D0274	Bitewings - 4 films	No Cost
D0277	Vertical bitewings - 7 to 8 films	No Cost
D0330	Panoramic film	No Cost
D0460	Pulp vitality tests	No Cost

PREVENTIVE

Code	Description	Co-Pay
D1110	Prophylaxis - adult	No Cost
D1120	Prophylaxis - child to age 14	No Cost
D1206	Fluoride Varnish – therapeutic application for moderate to high caries risk patients	No Cost
D1208	Fluoride treatment - excluding prophylaxis - child	No Cost
D1351	Sealant - per tooth - child	No Cost
D1510	Space maintainer-fixed unilateral	No Cost
D1515	Space maintainer-fixed bilateral	No Cost
D1520	Space maintainer - removable unilateral	No Cost
D1525	Space maintainer - removable bilateral	No Cost

ADJUNCTIVE GENERAL

Code	Description	Co-Pay
D9110	Palliative (emergency) treatment of pain - minor procedures	$ 31.00
D9120	Fixed partial denture sectioning	$ 15.00
D9220	Deep sedation/general anesthesia - first 30 minutes	$ 98.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$ 30.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$ 16.00
D9241	Intravenous conscious sedation/analgesia first 30 minutes	$104.00
D9242	Intravenous conscious sedation/analgesia each additional 15 minutes	$ 27.00
D9310	Consultation (diagnostic service provided by a dentist or physician other than requesting dentist or physician)	$ 28.00

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BASIC RESTORATIVE

Code	Description	Co-Pay
D2140	Amalgam-1 surface, primary or permanent	$ 32.00
D2150	Amalgam-2 surfaces, primary or permanent	$ 35.00
D2160	Amalgam-3 surfaces, primary or permanent	$ 45.00
D2161	Amalgam-4 or more surfaces, primary or permanent	$ 45.00
D2330	Resin-based composite - 1 surface anterior	$ 35.00
D2331	Resin-based composite - 2 surfaces anterior	$ 45.00
D2332	Resin-based composite - 3 surfaces anterior	$ 45.00
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle (anterior)	$ 60.00
D2391	Resin-based composite - 1 surface posterior	$ 51.00
D2392	Resin-based composite - 2 surfaces posterior	$ 68.00
D2393	Resin-based composite - 3 surfaces posterior	$ 85.00
D2394	Resin-based composite - 4 or more surfaces posterior	$ 97.00
D2930	Prefabricated stainless steel crown primary tooth	$ 81.00
D2931	Prefabricated stainless steel crown permanent tooth	$ 87.00
D2932	Prefabricated resin crown	$ 87.00
D2933	Prefabricated stainless steel crown with resin window	$108.00
D2940	Protective filling	$ 28.00
D2951	Pin retention-per tooth-in addition to restoration	$ 17.00

ENDODONTICS

Code	Description	Co-Pay
D3110	Pulp cap - direct (excluding final restoration)	$ 17.00
D3220	Therapeutic pulpotomy (primary tooth) excluding final restoration	$ 49.00
D3310	Root canal therapy-anterior (excluding final restoration)	$223.00
D3320	Root canal therapy-bicuspid (excluding final restoration)	$258.00
D3330	Root canal therapy-molar (excluding final restoration)	$324.00
D3346	Retreatment of previous root canal therapy-anterior	$262.00
D3347	Retreatment of previous root canal therapy-biscuspid	$307.00
D3348	Retreatment of previous root canal therapy-molar	$373.00
D3410	Apicoectomy/periradicular surgery anterior	$211.00
D3421	Apicoectomy/periradicular surgery bicuspid (first root)	$238.00
D3425	Apicoectomy/periradicular surgery molar (first root)	$284.00
D3426	Apicoectomy/periradicular surgery (each additional root)	$ 72.00
D3430	Retrograde filling - per root	$ 61.00
D3450	Root amputation - per root	$111.00

ORAL SURGERY

Code	Description	Co-Pay
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$ 39.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$ 75.00
D7220	Removal of impacted tooth soft tissue	$ 88.00
D7230	Removal of impacted tooth partially bony	$107.00
D7240	Removal of impacted tooth completely bony	$128.00
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications	$151.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$ 83.00
D7285	Biopsy of oral tissue - hard (bone, tooth)	$109.00
D7286	Biopsy of oral tissue - soft (all others)	$ 64.00
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$ 63.00
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$ 88.00
D7471	Removal of lateral exostosis - (maxilla-upper or mandible-lower)	$128.00

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ORAL SURGERY (Cont.)

Code	Description	Co-Pay
D7472	Removal of torus palatinus	$132.00
D7473	Removal of torus mandibularis	$142.00
D7510	Incision and drainage of abscess intraoral soft tissue	$ 48.00
D7960	Frenulectomy (frenectomy or frenotomy) separate procedure	$ 96.00

PERIODONTICS

Code	Description	Co-Pay
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$117.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$ 39.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$ 39.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$156.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	$132.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$334.00
D4261	Osseous surgery (including flap entry and closure) -one to three contiguous teeth or bounded teeth spaces per quadrant	$289.00
D4263	Bone replacement graft-first site in quadrant	$120.00
D4264	Bone replacement graft-each additional site in quadrant	$ 60.00
D4277	Free soft tissue graft procedure (including donor site surgery)	$234.00
D4278	Free soft tissue graft procedure (including donor site surgery), Each additional contiguous tooth or edentulous tooth position in same graft site	$117.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$ 70.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	$ 50.00
D4910	Periodontal maintenance procedures following active therapy (periodontal prophylaxis)	$ 40.00

SPECIAL RESTORATIVE

Code	Description	Co-Pay
D2520	Inlay-metallic-2 surfaces	$267.00
D2530	Inlay-metallic-3 or more surfaces	$301.00
D2543	Onlay-metallic three surfaces	$350.00
D2544	Onlay-metallic-four or more surfaces	$369.00
D2710	Crown-resin-based composite (indirect)	$160.00
D2740	Crown-porcelain/ceramic substrate	$398.00
D2750	Crown-porcelain fused to high noble metal	$383.00
D2751	Crown-porcelain fused to predominantly base metal	$334.00
D2752	Crown-porcelain fused to noble metal	$370.00
D2780	Crown-3/4 cast high noble metal	$364.00
D2781	Crown-3/4 cast predominantly base metal	$310.00
D2782	Crown-3/4 cast noble metal	$337.00
D2790	Crown-full cast high noble metal	$383.00
D2791	Crown-full cast predominantly base metal	$320.00
D2792	Crown-full cast noble metal	$366.00
D2910	Recement inlay, onlay or partial coverage restoration	$ 22.00
D2920	Recement crown	$ 27.00
D2950	Crown buildup (substructure) including any pins	$ 75.00
D2952	Post and core in addition to crown, indirectly fabricated	$109.00
D2953	Each additional indirectly fabricated post-same tooth	$ 16.00

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D2954	Prefabricated post and core in addition to crown	$ 89.00

SPECIAL RESTORATIVE (Cont.)

Code	Description	Co-Pay
D2957	Each additional prefabricated post-same tooth	$ 13.00
D2961	Labial veneer (resin laminate) laboratory	$225.00
D2962	Labial veneer (porcelain laminate) laboratory	$289.00

PROSTHODONTICS

Code	Description	Co-Pay
D5110	Complete denture (maxillary -upper)	$555.00
D5120	Complete denture (mandibular- lower)	$555.00
D5130	Immediate denture (maxillary -upper)	$569.00
D5140	Immediate denture (mandibular- lower)	$569.00
D5211	Upper partial denture - resin base (including any conventional clasps, rests and teeth)	$374.00
D5212	Lower partial denture - resin base (including any conventional clasps, rests and teeth)	$374.00
D5213	Upper partial denture - metal base with resin saddles (including any conventional clasps, rests and teeth)	$546.00
D5214	Lower partial denture - metal base with resin saddles (including any conventional clasps, rests and teeth)	$546.00
D5410	Adjust complete denture upper	$ 22.00
D5411	Adjust complete denture lower	$ 22.00
D5421	Adjust partial denture - upper	$ 22.00
D5422	Adjust partial denture - lower	$ 22.00
D5510	Repair broken complete denture base	$ 64.00
D5520	Replace missing/broken tooth complete denture (each tooth)	$ 54.00
D5610	Repair resin saddle or base partial denture	$ 52.00
D5620	Repair cast framework partial denture	$ 78.00
D5630	Repair/replace broken clasp partial denture	$ 78.00
D5640	Replace tooth on partial denture per tooth	$ 54.00
D5650	Add tooth to existing partial denture	$ 55.00
D5660	Add clasp to existing partial denture	$ 70.00
D5710	Rebase upper complete denture	$167.00
D5711	Rebase lower complete denture	$167.00
D5720	Rebase upper partial denture	$160.00
D5721	Rebase lower partial denture	$160.00
D5730	Reline complete upper denture (chairside)	$ 77.00
D5731	Reline complete lower denture (chairside)	$ 77.00
D5740	Reline upper partial denture (chairside)	$ 83.00
D5741	Reline lower partial denture (chairside)	$ 83.00
D5750	Reline complete upper denture (laboratory)	$137.00
D5751	Reline complete lower denture (laboratory)	$137.00
D5760	Reline upper partial denture (laboratory)	$130.00
D5761	Reline lower partial denture (laboratory)	$130.00
D5850	Tissue conditioning upper denture	$ 46.00
D5851	Tissue conditioning lower denture	$ 46.00
D6210	Pontic - cast high noble metal	$365.00
D6211	Pontic - cast predominantly base metal	$317.00
D6212	Pontic - cast noble metal	$327.00
D6240	Pontic - porcelain fused to high noble metal	$372.00
D6241	Pontic - porcelain fused to predominantly base metal	$336.00
D6242	Pontic - porcelain fused to noble metal	$354.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$164.00
D6750	Crown - porcelain fused to high noble metal	$376.00

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PROSTHODONTICS (Cont.)

Code	Description	Co-Pay
D6751	Crown - porcelain fused to predominantly base metal	$337.00
D6752	Crown - porcelain fused to noble metal	$359.00
D6780	Crown - 3/4 cast high noble metal	$350.00
D6790	Crown - full cast high noble metal	$370.00
D6791	Crown - full cast predominantly base metal	$326.00
D6792	Crown - full cast noble metal	$362.00
D6930	Recement fixed partial denture	$ 47.00
D6940	Stress breaker	$ 83.00

ORTHODONTICS

Code	Description	Co-Pay
D8010	Limited orthodontic treatment of the primary dentition	$ 668.00
D8020	Limited orthodontic treatment of the transitional dentition	$ 835.00
D8030	Limited orthodontic treatment of the adolescent dentition	$ 934.00
D8040	Limited orthodontic treatment of the adult dentition	$1,041.00
D8050	Interceptive orthodontic treatment of the primary dentition	$ 812.00
D8060	Interceptive orthodontic treatment of the transitional dentition	$ 918.00
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,875.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,980.00
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,203.00
D8210	Removable appliance therapy	$ 201.00
D8220	Fixed appliance therapy	$ 264.00
D8660	Pre-orthodontic treatment visit	$ 39.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$ 237.00

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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

Health Plan

1800 Grant Street, Suite 225
Denver, CO 80203
303-860-4199

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