GROUP DENTAL PLAN
BENEFIT BOOKLET

For

UNIVERSITY OF COLORADO
and AFFILIATES

University of Colorado #6451
University of Colorado Hospital #6473
University Physicians, Inc. #6457

EPO 6A PLAN

Effective: July 1, 2013

Exclusive Panel Option (EPO), a feature of the Delta Dental PPO
Schedule of Benefits
UNIVERSITY OF COLORADO and AFFILIATES

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

Control Plan - Delta Dental of Colorado
Plan Year – The Plan Year will run from July 1st to June 30th

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

***Services received from a Non-PPO Dentist are not a covered benefit.**

Age

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

Deductible - None

Maximum (July 1st - June 30th)

Class	Type	Network	Amt
All Covered Classes Except Ortho	Individual coverage amount	PPO	$2000
Orthodontic Classes	Individual lifetime	PPO	$4000

Enrollment Type:

Open Enrollment. Open Enrollment means a period of time occurring prior to July 1st during which eligible Employees may choose to enroll themselves and/or their eligible Dependents in the Plan, or change from one coverage option to another if the Contract issued to the Group permits them to do so. Coverage will become effective on the Group's Anniversary Date.

Under the Delta Dental EPO plan, all services must be provided a Colorado PPO Participating Dentist.

- 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.

In the event services are provided by a non-PPO Participating Dentist, the subscriber or dependent will be responsible for all charges incurred. 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 Baca, Bent, Cheyenne, Costilla, Crowley, Delta, Elbert, Gilpin, Gunnison, Hinsdale, Jackson, Kiowa, Lake, Mineral, Moffat, Ouray, Pitkin, Prowers, Rio Blanco, Saguache, San Juan, San Miguel, Sedgwick, Washington, and Yuma.

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

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.
Any service NOT LISTED is the responsibility of the patient and is available at the dentist's allowable fee.

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

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
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

Services MUST be performed by a PPO panel dentist in order to be payable under this program.
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SPECIAL RESTORATIVE (Cont.)

Code	Description	Co-Pay
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
D2954	Prefabricated post and core in addition to crown	$ 89.00
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

PROSTHODONTICS (Cont.)

Code	Description	Co-Pay
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
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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Services are subject to the limitations and exclusions listed in this booklet.
Any service NOT LISTED is the responsibility of the patient and is available at the dentist's allowable fee.

Delta Dental of Colorado
Group Dental Plan

CONTACT US

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

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

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

Customer Service:
1-800-610-0201

TABLE OF CONTENTS

ELIGIBILITY

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

SUBSCRIBER

The Subscriber is a Member in whose name the membership is established. An employee who has a regular work week, a Regent Board member, or special category retiree as specified in the Plan Document is eligible to enroll for benefits as a Subscriber. An employee must contact the employer for the minimum number of hours that must be worked per week and other requirements to qualify for benefits.

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 newborns 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 while covered under the Plan, 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. Another option is to enroll the grandchild under a separate individual insurance policy.

DEPENDENT ELIGIBILITY

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

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

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

How to Find a Dentist

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

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

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

BENEFITS/COVERAGE (What Is Covered)

COVERED DENTAL SERVICES

DIAGNOSTIC & PREVENTIVE SERVICES

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

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

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

PROCEDURE	BENEFIT DESCRIPTON
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 perio conditions, • Pregnancy with documented perio conditions, • Cardiovascular disease with documented perio 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.
Fluoride Treatment	Covered 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 only if no other service is provided during the visit except an exam and/or x-rays.

BASIC SERVICES

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

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

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

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

PROCEDURE	**BENEFIT DESCRIPTON**
Amalgam Fillings (silver fillings)	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing amalgam filling is allowed if at least 12 months have passed since the existing amalgam was placed.
Composite Resin (white plastic) Fillings	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing composite resin filling is allowed if at least 12 months have passed since the filling was placed. Composite resin fillings on back teeth will be covered up to the cost of an amalgam filling.
Stainless Steel Crowns, Resin Crowns	Covered when the tooth cannot be restored by a filling and then 1 time in a 36 month period.
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, 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.
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.
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.
Osseous Surgery or 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 biopsies, alveoloplasty with extractions, incision and drainage of abscess and frenectomy or frenulectomy.
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 DESCRIPTON
Re-Cement crowns, Inlays and onlays	Covered after 6 months from initial insertion.
Re-Cement Fixed Bridges	Covered after 6 months from initial insertion of fixed bridge.
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 once in 60 months per tooth when needed to retain a crown or onlay and only when need is due to extensive loss of tooth structure caused by decay or fracture. Not covered for children under age 12.
Post and Core (in conjunction with a Crown or Onlay)	Covered once in 60 months per tooth for endodontically treated teeth. Must be needed to retain a crown or onlay, and when necessary due to extensive loss of tooth structure caused by decay or fracture. Not covered for children under age 12.
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.

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

LIMITATIONS/EXCLUSIONS
(What Is Not Covered)

GENERAL LIMITATIONS – ALL SERVICES

a. The benefit allowed for a temporary service and the final service is limited to the benefit allowed for the final dental service, unless the temporary service is specifically included as a Covered Service of the Contract.
b. 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.
c. 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.
d. Local anesthesia is considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.

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.
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 Service for cosmetic purposes.
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 of Colorado. Services performed by any person other than a person licensed to perform such Services. Services performed to treat any condition, other than an oral or dental disease, malformation, abnormality or condition.
u) Teaching in oral hygiene or diet planning.
v) Completion of forms. Providing diagnostic information or records. Copying of x-rays or other records.
w) Replacement of lost, stolen or damaged appliances.
x) Repair of appliances altered by someone other than a Dentist.
y) Any Services not included in Appendix A – Patient Co-Payment.
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) Services from a Dentist other than a Colorado PPO Participating Dentist.
ee) Injuries you cause yourself.
ff) Provisional splinting.
gg) Bone grafting when done in the same site as a tooth extraction, implant, apicoectomy or hemisection.
hh) Services provided for treatment of teeth retained in relation to an Overdenture.
ii) Any Prosthodontic service provided within 60 months of Special Restorative services involving the same teeth.
jj) Any Special Restorative service provided within 60 months of fixed Prosthodontic services involving the same teeth.
kk) Fixed and removable Prosthodontic appliances (bridges and partials) are not a benefit in the same arch except when the fixed denture (bridge) replaces front teeth. Allowance is limited to the allowance for the removable partial denture.

MEMBER PAYMENT RESPONSIBILITY

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

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

CLAIM PROCEDURES (How to File a Claim)

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

If you elect treatment for any emergency procedures from a Dentist who does not participate as a PPO Provider with Delta Dental, you may need to file your own claim.

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

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

PRE-TREATMENT ESTIMATE

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

GENERAL POLICY PROVISIONS

COORDINATION OF BENEFITS

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

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

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

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

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

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

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

SUBROGATION

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

HIPAA

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

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

j) Ensure that any agent to whom it provides electronic PHI agrees to implement security measures to protect the information.
k) Report to the group health plan any security incident of which it becomes aware.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

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

How We May Use and Disclose Health Information About You

We may use and disclose protected health information for treatment, payment, and health care operations. For example, we may use and disclose protected health information:

1. To communicate with the dentist who provides your care;
2. To determine how much or whom we should pay for services;
3. To assess the quality of care that our participating dentists provide.

Other ways that we may use and disclose your health information are listed below, along with some examples.

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

To Your Family and Friends: We may disclose your health information to a family member, friend or other person with your permission.

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

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

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

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

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

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

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

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

Your Rights Regarding Health Information About You

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

Your Right to Inspect and Copy Your Health Information: To inspect and copy such information, you must submit your request in writing. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request.

Your Right to Amend Protected Health Information: You may request that Delta Dental change your health information, although we are not required to do so. If your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make your request in writing. You must also provide a reason for your request.

Your Right to an Accounting of Disclosures Made by Delta Dental: You may request an accounting of disclosures made for purposes other than treatment, payment, health care operations or made to you. You must submit your request in writing. Your request should specify a time period of up to six years and may not include dates before April 14, 2003. Delta Dental will provide the first accounting per 12-month period free of charge. We may charge you for additional reports.

Your Right to Request Restrictions on Uses and Disclosures: Although you have this right, Delta Dental is not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing.

Your Right to Request Confidential Communications Through a Reasonable Alternative Means or at an Alternative Location: To request confidential communications, you must submit your request in writing. We are not required to agree to your request, unless such disclosure could cause you to be in danger.

Your Right to a Paper Copy of this Notice: You may obtain additional paper copies of this Notice by sending us a written request. You may also obtain a copy of this Notice at our website www.deltadentalco.com.

Your Right to Obtain Additional Information or File a Complaint: Send us a written request if you would like to have a more detailed explanation of these rights. Complaints about how we handle your health information should be submitted in writing. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. Delta Dental will not retaliate against you in any way if you choose to file a complaint with us or with the department.

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

Send Written Requests Regarding this Privacy Notice to:
Privacy Officer
PO Box 5468
Denver CO 80217-5468
1-800-233-0860

TERMINATION/ NONRENEWAL/CONTINUATION

Coverage will terminate at the earliest of:

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

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

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

Continued Health Coverage required by the State of Colorado

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

Continuation Health Coverage Through Employer

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

EXTENDED COVERAGE

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

If a Covered Service was Started before cancellation, but the Covered Service is Completed after Delta Dental cancellation, Delta Dental will pay Benefits for the Covered Service as follows:

- Benefits will be paid in the amount that would have been paid and subject to the same terms and conditions of the Contract that would have applied, if the Person's coverage was still in effect.
- Benefits are payable if the Covered Service is Completed within 60 days after the date the Person's coverage ended.

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

APPEALS AND COMPLAINTS

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

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

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

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

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

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

INFORMATION ON POLICY AND RATE CHANGES

If there are changes to the benefits under this plan or to the premium amount you must pay, whether due to a change in the agreement between your employer and Delta Dental or due to changes to the plan itself, your employer must provide notice to you. If there are changes to the information provided in this document, we will issue revised materials to you.

DEFINITIONS

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.

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.

COPAYMENT means the dollar amount of a Covered Service that is payable by the Covered Person.

COVERED AMOUNT means the lesser of the Colorado PPO Dentist's Allowable Fee or the fee actually charged by a Colorado PPO Dentist. No payment will be made for Services provided by a Dentist who is not a Colorado PPO Dentist.

DENTIST means a person licensed to practice dentistry.

DEPENDENT means any individual eligible for coverage under the Subscriber's policy by virtue of his or her relationship with Employee. The various relationships that create Dependent eligibility are set forth in the Eligibility section of this Benefit Booklet.

No one may be covered as a Dependent and also as an Employee under this Contract. If both parents are covered as Employees, children may be covered as Dependents of one parent only.

Persons in active military service are not eligible Dependents.

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

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

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

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

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

STARTED means

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

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

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

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

Customer Service:
1-800 610-0201

7/13