



# Delta Dental PPO Plus Direct Plan

## Effective: January 1, 2011

**You will receive the best benefits available on this plan by choosing a PPO Dentist.** If you do not use a PPO dentist, and your dentist charges more than the PPO Dentist's allowable fee, you will be responsible for any excess. If you see a Premier Dentist, you are responsible for the difference between the PPO Dentist's Allowable Fee and the fee from the Premier Maximum Plan Allowance. If you see a non-participating dentist, you are responsible for the difference between the PPO Dentist's Allowable Fee and the billed charges.





## Delta Dental PPO Summary of Dental Plan Benefits PPO Plus Direct Plan

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

**Control Plan** - Delta Dental of Colorado

**Benefit Year** – 12 Consecutive Months from the first day of the month in which you initially enroll

	<b>PPO Dentist</b>	<b>*Delta Dental Premier or Non-Participating Dentist</b>	
<b>Covered Services</b>	<b>Plan Pays</b>	<b>Plan Pays</b>	<b>Waiting Period</b>
<b>Type I-Diagnostic &amp; Preventive Services</b>			
Oral Exams and Cleanings	100% of a PPO Dentist's Allowable Fee	90% of a PPO Dentist's Allowable Fee	NONE
X-Rays			
Sealants			
Fluoride Treatment			
<b>Type II-Basic Services</b>			
Basic Restorative (Fillings)	80% of a PPO Dentist's Allowable Fee	70% of a PPO Dentist's Allowable Fee	6 MONTHS
Simple Extractions			
<b>Type IIIA-Major Services</b>			
Oral Surgery	50% of a PPO Dentist's Allowable Fee	40% of a PPO Dentist's Allowable Fee	12 MONTHS
Endodontics (Root Canal Therapy)			
Periodontics (Gum Disease Treatment)			
Prosthodontics (Dentures, Bridges)			
<b>Type IIIB-Major Services</b>			
Prosthodontics (Dentures, Bridges)	50% of a PPO Dentist's Allowable Fee	40% of a PPO Dentist's Allowable Fee	24 MONTHS
Special Restorative (Crowns, Inlays, Onlays)			

**Orthodontics is not a covered benefit.**

\*If you do not use a PPO dentist, and your dentist charges more than the PPO Dentist's allowable fee, you will be responsible for any excess. If you see a Premier Dentist, you are responsible for the difference between the PPO Dentist's Allowable Fee and the fee from the Premier Maximum Plan Allowance. If you see a non-participating dentist, you are responsible for the difference between the PPO Dentist's Allowable Fee and the billed charges.

**To join this plan, you cannot have other dental coverage.**

**Child Dependent Age Limit is to the end of the month in which they attain age 26.**

Also eligible at your option are your spouse and your dependent children to the end of the month in which they turn the dependent age shown above.

**Maximum Payment** - \$1,500 Individual Benefit Year Maximum on Type I, II, IIIA and IIIB Services.

**Deductible** - \$50 deductible per person per benefit year on Type II, Type IIIA, and Type IIIB Covered Services.

**Enrollment** – Annually on the enrollment anniversary, any eligible Subscriber currently enrolled in one of the individual plans offered may elect to switch between the plans. Waiting periods will apply to all new enrollees and any subscriber changing from the Patient Direct plan.

**Enrollment of Dependents:**

- a. Newly acquired dependents may be enrolled within thirty-one (31) days of acquisition. Newborn children may be enrolled within thirty-one (31) days of birth
- b. Any eligible dependents not enrolled as described above or who are enrolled and subsequently dropped from the plan will not be eligible to enroll until the next anniversary date.
- c. Any eligible dependents that suffer involuntary loss of coverage through another source will be allowed to enroll with satisfactory proof of coverage loss. Such dependents must be enrolled within thirty-one (31) days of loss of coverage or at the enrollment anniversary.

**These changes become effective on the first of the month following written notification.**

**Waiting Period** – There is a **6 month wait for Type II Services, a 12 month wait for Type IIIA Services and a 24 month wait for Type IIIB Services.** These waiting periods do not apply to Covered Services Necessary for the treatment of a covered Dental Injury sustained while covered (if started within 60 days of the Dental Injury).

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

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

**PPO Participating Dentist**

Advantages of seeing a PPO Dentist include:

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

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

**Premier Participating Dentist (Non-PPO)**

You have the option of seeing a Premier Dentist, but you may incur additional costs:

- Claim forms are submitted directly to Delta Dental by the Dentists.
- You are responsible only for applicable deductible and coinsurance for covered procedures.
- The member is responsible for the difference between the PPO Dentist's Allowable Fee and the fee from the Premier Maximum Plan Allowance.

**Non-Participating Dentist (Non-PPO)**

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

- You may be responsible for payment in full to the Dentist and for filing your claim with Delta Dental for reimbursement
- You are responsible for the difference between the PPO Dentist's Allowable Fee and the full fee charged by the Dentist.

**COVERED AMOUNT** means the lesser of the PPO Dentist's Allowable fee or the fee actually charged

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## ELIGIBILITY

All eligible Subscribers and their dependents who enroll will be covered on the effective date. Your Dependents who can be covered are your lawful spouse and your dependent children up to age 26.

## TERMINATION OF COVERAGE

Coverage will terminate at the earliest of:

- The last day of the month Delta Dental receives a written request to terminate coverage. Delta Dental must receive the written notification by the 25<sup>th</sup> day of the month in order to terminate the policy on the 1<sup>st</sup> of the following month. If the notification is received after the 25<sup>th</sup> day of the month, the termination will be delayed an additional month and premium will still be due;
- The end of the period for which Premium is paid;
- As to any Dependent, the date the person no longer qualifies as a Dependent and loses their Dependent status. Loss of Dependent status can occur for many different reasons. Therefore, you are required to notify Delta Dental within 60 days of the event or the loss of coverage, whichever is later.

## EXTENDED COVERAGE

Delta Dental's responsibility to pay for Covered Services for a Person will end if this Contract is terminated or if the Person ceases to be a Covered Person under the terms of the Contract. Delta Dental will cover no further care or Services with the following exception:

If the Covered Person has a Covered Service Started while still covered under the Contract, but the Covered Service is Completed after Delta Dental no longer covers the Person, Delta Dental will pay Benefits for the Covered Service as follows:

- No benefit is payable if the Covered Service is Started after the day the Person's coverage ends.
- Benefits are payable only in the amount that would have been payable 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 only if the Covered Service is Completed within 60 days after the date the Person's coverage ended.

## HOW TO USE THE DELTA DENTAL PLAN

### How to Find a Dentist

There are two easy ways that you can find out if your Dentist is participating with Delta Dental:

**Website:** You may log onto our web page at [www.deltadentalco.com](http://www.deltadentalco.com) and use the Dentist Search feature. This feature allows you to search by city, state or zip code and provides a listing of Dentists in your area.

**Integrated Voice Response (IVR):** Delta Dental's IVR allows you to call and request a listing of Dentists in your area and receive it by mail or fax. Call 1-800-610-0201 and follow the prompts.

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

## CLAIMS SUBMISSION

If your Dentist is a participating Dentist of Delta Dental, the claim form for benefits will be filed by your Dentist. The patient should complete the patient section of the claim form and sign the form to indicate that he authorizes release of the information to Delta Dental.

If you elect treatment from a non-participating Dentist, you may be responsible for filing your claim.

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

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

## PRE-TREATMENT ESTIMATE

Before beginning a course of treatment for which the charge is expected to be \$400 or more, a description of that course of treatment may be submitted to Delta Dental before treatment is begun. Delta Dental will provide an estimate of the Benefits payable for the planned course of treatment of a Covered Person. Pre-treatment estimates are not required and are provided as a service to the Covered Person and Dentist in order to allow for appropriate planning.

## COVERED DENTAL SERVICES

### TYPE I – DIAGNOSTIC & PREVENTIVE SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Oral Exam (All exam types).	Limited to one time in any 6 consecutive month period. Only one comprehensive or detailed and extensive oral examination is a benefit per Covered Person per dental office. No benefits will be provided for diagnosis, treatment planning or consultation by the treating Dentist.
Dental Cleaning	Limited to one time in any 6-month period for Covered Person(s). No benefit is allowed if performed within 6 months of a periodontal maintenance procedure. For payment purposes, an adult cleaning is not a benefit for persons under age 14. For individuals with the conditions listed below, 2 additional cleanings (or any procedure that includes a component) will be provided during a 12 month period. <ul style="list-style-type: none"> <li>• People who are diabetic and have documented periodontal (gum) conditions or;</li> <li>• Women who are pregnant and have documented periodontal (gum) conditions or;</li> <li>• People with cardiovascular disease who have documented periodontal (gum) conditions or;</li> <li>• People with kidney failure or who are undergoing dialysis and;</li> <li>• People who have an immune system which is suppressed because of chemotherapy or radiation treatment, HIV Positive status, Organ Transplant or stem cell (bone marrow) transplant.</li> </ul>
Fluoride Treatment	Limited to one time in any 12 consecutive month period. Limited to children under the age of 16.
Sealants	Limited to one time per tooth in any 36 consecutive month period. Allowed only for the occlusal surface of decay-free and previously unrestored permanent first and second molars for children under the age of 15. There is no separate benefit for preparation or conditioning of the tooth or any other procedure associated with the sealant application.
Space Maintainer	Limited to children under the age of 14 to maintain space left by prematurely lost deciduous (baby) posterior teeth.
Bitewing x-rays	Limited to one time in any 12 consecutive month period.
Complete Mouth Survey or Panoramic x-ray	Limited to one time in any 60 consecutive month period.
Individual Periapical x-rays	A maximum of 4 periapical x-rays per 12-month period.
Intraoral Occlusal x-rays Extraoral x-rays	Limited to the allowance for a complete 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.

### TYPE II - BASIC SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Oral Pathology Lab Procedures	A benefit only if accompanied by a pathology report.
Amalgam Fillings (silver fillings)	Multiple fillings on one surface will be paid as a single filling. Benefits for the replacement of an existing amalgam filling is allowed if at least 24 months have passed since the existing amalgam was placed.
Composite Resin (white plastic) Fillings	Benefits for the replacement of an existing composite resin filling are allowed if at least 24 months have passed since the existing filling was placed. Benefits for composite resin fillings on posterior teeth will be limited to the benefit for the corresponding amalgam filling.
Sedative Filling	A separate benefit if no other restorative service is performed on the same tooth on the same date. Not a benefit during a course of endodontic therapy.
Pin Retention	Benefit only in conjunction with a basic (amalgam or composite) filling. A benefit one time per filling.
Simple Extractions	The benefit includes an allowance for local anesthesia and routine post-operative care, which are not separately allowed as benefits.
Root Removal - Exposed Roots	The benefit includes an allowance for local anesthesia and routine post-operative care, which are not separately allowed as benefits.
Palliative Treatment	Paid as a separate benefit only if no other service is rendered during the visit except an exam and/or x-rays.

**TYPE IIIA - ENDODONTIC SERVICES****PROCEDURE** **BENEFIT DESCRIPTION**

Therapeutic Pulpotomy	A benefit for deciduous teeth only.
Root Canal Therapy	A benefit once per tooth. Pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care are not separately allowed as benefits.
Root canal therapy, retreatment	A benefit only if the original root canal procedure was performed at least 36 months earlier.
Apexification/recalcification (apical closure/calcific repair of perforations, root resorption, etc.)	A benefit once per root. Pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care are not separately allowed as benefits.
Apicoectomy	A benefit once per root in any 36 consecutive month period. Pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care are not separately allowed as benefits.
Retrograde Filling (per root)	A benefit once per root in any 36 consecutive month period. Pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care are not separately allowed as benefits.
Root Amputation (per root)	Pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care are not separately allowed as benefits.
Hemisection (includes any root removal)	Pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care are not separately allowed as benefits.

**TYPE IIIA - PERIODONTIC SERVICES****PROCEDURE** **BENEFIT DESCRIPTION**

Provisional Splinting	Splinting is not a benefit. In addition, no payment will be made for crowns or inlays or other cast or laboratory prepared restorations made for the purpose of splinting.
Periodontal Scaling and Root Planing - Per Quadrant	Limited to one time per quadrant of the mouth in any 24 consecutive month period.
Periodontal Maintenance Procedures Following Active Therapy	A benefit only if at least 3 months have passed since the completion of active periodontal therapy and only one time thereafter in any 6 consecutive month period. Not a benefit if performed within 6 months of a cleaning.
Gingivectomy	Only one periodontal surgical procedure is a benefit per area of the mouth in any 36 consecutive month period. If less than a full quadrant is treated or requires treatment, benefits will be prorated to reflect the portion of the quadrant actually treated or the portion that requires treatment. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Gingival Flap Procedure	Only one periodontal surgical procedure is a benefit per area of the mouth in any 36 consecutive month period. If less than a full quadrant is treated or requires treatment, benefits will be prorated to reflect the portion of the quadrant actually treated or the portion that requires treatment. Root planning, local anesthesia and routine post-operative care are not separately allowed as benefits.
Crown lengthening-hard tissue, by report	Not a benefit if performed on the same date as osseous surgery, crown preparation or other restoration.
Osseous Surgery and Grafts, Guided tissue regeneration (includes surgery and re-entry), Pedicle Soft Tissue Graft, Free Soft Tissue Graft (Including Donor Site)	Only one periodontal surgical procedure is a benefit per area of the mouth in any 36 consecutive month period. If less than a full quadrant is treated or requires treatment, benefits will be prorated to reflect the portion of the quadrant actually treated or the portion that requires treatment. Local anesthesia and routine post-operative care are not separately allowed as benefits.

**TYPE IIIA - COMPLEX ORAL SURGERY SERVICES**

When services for an assistant surgeon are a benefit, according to Delta Dental, the Covered Amount will not exceed 20% of the surgeon's fee.

**PROCEDURE** **BENEFIT DESCRIPTION**

Complex Oral Surgery Services	Local anesthesia and routine post-operative care are not separately allowed as benefits.
Alveoplasty	Not a benefit when performed on the same date of service as the extractions. Includes local anesthesia and routine post-operative care.

**TYPE IIIA - PAIN MANAGEMENT SERVICES**

<b>PROCEDURE</b>	<b>BENEFIT DESCRIPTION</b>
General Anesthesia	Paid as a separate benefit only when administered in conjunction with covered oral surgical procedures.
I.V. Sedation	Paid as a separate benefit only when administered in conjunction with covered complex oral surgical procedures.

**TYPE IIIA - ADJUSTMENT AND REPAIR SERVICES**

<b>PROCEDURE</b>	<b>BENEFIT DESCRIPTION</b>
Re-Cement Inlays	A benefit only when performed more than 6 months after initial insertion of inlay.
Re-Cement Crowns	A benefit only when performed more than 6 months after initial insertion of crown or onlay.
Repairs to Crowns	Subject to Delta Dental's consultant review.
Re-Cement Fixed Bridges	A benefit only when performed more than 6 months after initial insertion of fixed bridge.
Repairs to Fixed Bridges	Subject to Delta Dental's consultant review.

**TYPE IIIA - DENTURE ADJUSTMENT, REPAIR, RELINE AND REBASE SERVICES**

<b>PROCEDURE</b>	<b>BENEFIT DESCRIPTION</b>
Denture Adjustments	A benefit only if performed more than 6 months after the insertion of the complete or partial denture.
Repairs to Full and Partial Dentures	A benefit only if performed more than 6 months after the insertion of the complete or partial denture.
Tissue Conditioning Per Denture Unit	Limited to two times in any 36 consecutive months.
Relining Dentures Rebasing Dentures	Limited to relining or rebasing done more than 6 months after the initial insertion and then not more than one time in any 36 consecutive month period.

**TYPE IIIB - INLAY, ONLAY AND CROWN SERVICES**

(Temporary restorations and appliances are not separately allowed as benefits.)

<b>PROCEDURE</b>	<b>BENEFIT DESCRIPTION</b>
Metallic Inlays	Allowance for inlays will be limited to the allowance for an amalgam filling for the same number of surfaces, and then only if more than 84 months have elapsed since the last placement. This time requirement applies even if the existing inlay or onlay was not provided under this Contract. Not a benefit for children under age 16.
Crowns and Metallic Onlays	Benefit only when the tooth cannot be restored by an amalgam or composite filling, and then only if more than 84 months have elapsed since the last placement. This time requirement applies even if the existing crown or onlay was not provided under this Contract. <b>Not a benefit for children under age 16.</b>
Stainless Steel Crowns, Resin Crowns	Benefit only when the tooth cannot be restored by a filling and then only 1 time in any 36 consecutive month period. <b>Limited to children under the age of 16.</b>
Core (Crown) Buildup including any pins	Benefit when required for retention of a crown or onlay and only when necessary due to extensive loss of tooth structure caused by decay or fracture.
Post and Core (in conjunction with a Crown or Onlay)	Benefit on endodontically treated teeth, when required for retention of a crown or onlay and only when necessary due to extensive loss of tooth structure caused by decay or fracture.

**TYPE IIIB - FIXED BRIDGEWORK SERVICES**

<b>PROCEDURE</b>	<b>BENEFIT DESCRIPTION</b>
Fixed Bridges (Only a benefit to replace a Functioning Natural Tooth that was extracted while the patient was covered under the Contract.)	Benefits for the replacement of an existing fixed bridge are a benefit only if the existing fixed bridge is more than 84 months old, is not serviceable, and cannot be repaired. This time requirement applies even if the existing fixed bridge was not provided under this Contract.
Core (Bridge) Buildup including any pins (in conjunction with a Bridge Abutment)	Benefit when required for retention of a fixed bridge and only when necessary due to extensive loss of tooth structure caused by decay or fracture.
Post and Core (in conjunction with a fixed bridge)	Benefit on endodontically treated teeth, when required for retention of a fixed bridge and only when necessary due to extensive loss of tooth structure caused by decay or fracture.

## TYPE IIIB - DENTURE AND PARTIAL DENTURE SERVICES

### PROCEDURE

### BENEFIT DESCRIPTION

<p>Full Dentures (Only a benefit if it includes the replacement of at least one Functioning Natural Tooth that was extracted while the patient was covered under this Contract.)</p>	<p>Benefit for replacement is a benefit only if more than 60 months have elapsed since the last placement and it cannot be repaired or made serviceable. This time requirement applies even if the existing denture was not provided under this Contract. There are no additional benefits for personalized dentures, overdentures or associated procedures.</p>
<p>Partial Dentures (Only a benefit to replace a Functioning Natural Tooth that was extracted while the patient was covered under this Contract.)</p>	<p>Benefit for replacement is a benefit only if more than 60 months have elapsed since the last placement and it cannot be repaired or made serviceable. This time requirement applies even if the existing partial denture was not provided under this Contract. There are no additional benefits for precision or semi-precision attachments. The benefit for a partial denture includes any clasps and rests and all teeth. Not a benefit for Covered Persons under 16 years of age.</p>

## GENERAL LIMITATIONS – ALL SERVICES

### a. Alternate Benefits

There is often more than one service or supply that can be used to treat a dental problem or disease. In determining the benefits allowed on a claim, different materials and methods of treatment will be considered. The Covered Service will be limited to the Covered Amount for the least costly Covered Service that meets broadly 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 than Delta Dental determines to be satisfactory for the treatment of the condition. Delta Dental will pay a benefit toward the cost of the selected procedure or material at the Coinsurance level shown on the Declaration page. Payment will be limited to the Covered Amount for the least costly treatment. **Alternate benefits will not be given on non-covered services.**

### b. Benefits for temporary services

Temporary dental services will be considered an integral part of the final dental service rather than as a separate service. The combined benefit allowed for a temporary service and the final dental service will be limited to the maximum benefit allowed for the final dental service.

### c. Separate charges for services related to a primary procedure

When certain complicated dental procedures are performed, other less extensive procedures are performed at the same time as component parts of the primary procedure. These less extensive procedures are considered to be integral components of the primary procedure. Even if the Dentist bills separately for the primary procedure and each of its component parts, the total benefit allowed for all related charges will be limited to the maximum benefit allowed for the primary procedure.

### d. Completed dental Services

Completed dental Services are Benefits 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. Time frame limitations apply to both this and any other Delta Dental plan in which the Covered Person was enrolled.

## EXCLUSIONS

- a) Services for injuries or conditions which are compensable under Worker's Compensation or employer's liability laws, or Services which are provided to the Covered Person by any federal or state government agency or are provided without cost to the Covered Person by any municipality, county or other political subdivision, or any Services for which the Covered Person would have no obligation to pay in absence of this coverage, except as such exclusion may be prohibited by law.
- b) Completed dental Services are Benefits 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) Any Covered Service Started when the person was not eligible for such Service under this Contract including during any applicable Waiting Period.
- d) Services for treatment of congenital (present at birth) or developmental (following birth) malformations, except intraoral dental Services for treatment of a condition which is related to or developed as a result of cleft lip and/or cleft palate, unless otherwise included as a Covered Service of this Contract.
- e) Any procedure, service or supply provided primarily for cosmetic purposes. Facings or Veneers placed on crowns or Bridge units for molar teeth 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 fee.
- f) Services for restoring tooth structure lost from wear, erosion, attrition, abrasion or abfraction.
- g) Services related to protecting, altering, correcting, stabilizing, rebuilding or maintaining teeth due to improper alignment, occlusion or contour.
- h) Services related to periodontal stabilization of teeth.

- i) Habit appliances, night guards, occlusal guards, athletic mouth guards and gnathological (jaw function) Services, bite registration or analysis, or any related Services.
- j) Pre-medication, analgesia, hypnosis or any other patient management Services (except covered anesthetic Services).
- k) Charges for prescription drugs.
- l) Any Experimental or Investigational Procedures.
- m) Services that may otherwise have been covered, but due to the patient's underlying condition would not prove successful to improve the oral health of the patient.
- n) Any procedures done in anticipation of future need (except Covered Preventive Services).
- o) Hospital costs and any additional fees charged by the Dentist or hospital for hospital services or visits, or charges for use of any facility.
- p) Any anesthesia service not specifically included in Covered Services.
- q) Intraoral grafts when done in areas where a tooth/teeth are not present.
- r) Extraoral grafts (grafting of tissues or other substances from outside the mouth to or into oral tissues), augmentations or implants and/or any associated appliances. Removal of implants or any associated Services.
- s) Myofunctional therapy or speech therapy.
- t) Services for the treatment of any disturbances of the temporomandibular joint (TMJ), facial pain, or any related conditions, including any related diagnostic, preventive or interceptive Services.
- u) Services not performed in accordance with the laws of the State of Colorado, Services performed by any person other than a person authorized by license to perform such Services, or Services performed to treat any condition, other than an oral or dental disease, malformation, abnormality or condition.
- v) Oral hygiene instructions or dietary instructions.
- w) Completion of forms, providing diagnostic information or records, or duplication of x-rays or other records.
- x) Replacement of lost, stolen or damaged appliances.
- y) Repair of appliances altered by someone other than a Dentist.
- z) Any Services including any associated Services or procedures not specifically included in Covered Services.
- aa) Services for which charges would not have been made if this coverage had not existed, except for Services as provided under Medicaid.
- bb) Missed appointment charges.
- cc) Preventive control programs, including home care items.
- dd) Plaque control programs.
- ee) Self-inflicted injuries.
- ff) The initial placement of a full denture or partial denture unless the appliance replaces at least one Functioning Natural Tooth that was extracted while the Person was covered under this Contract. Only one full or partial denture is a benefit per arch in any 60-month period.
- gg) The initial placement of a fixed bridge unless it includes the replacement of a Functioning Natural Tooth extracted while the Person was insured under this Contract and only if that tooth was not an Abutment to an existing fixed bridge which is less than 84-months old. If a bridge replaces more than one extracted permanent Natural Tooth, benefit will be limited to the replacement of those teeth which were extracted while the Person was covered under the Contract.
- hh) Replacement of a complete denture, partial denture, or fixed bridge is not a Covered Service unless:
  1. replacement of the current full or partial denture occurs at least 60 months after the initial date of insertion, even if the existing appliance was not provided under this Contract; or
  2. replacement of an existing fixed bridge occurs at least 84 months after the initial date of insertion, even if the existing appliance was not provided under this Contract; or
  3. the replacement appliance is required by the Necessary extraction of a Functioning Natural Tooth while the Person is covered; or
  4. the replacement is made Necessary by a covered Dental Injury to Sound Natural Teeth provided the treatment is Started within 60 days of the injury. (Chewing injuries are not considered covered Dental Injuries).
- ii) The replacement of a fixed bridge unless the existing fixed bridge is at least 84 months old, is not serviceable and cannot be repaired. This time requirement applies even if the existing fixed bridge was not provided under this Contract.
- jj) The replacement of an existing crown, inlay, onlay or other cast restoration, unless the existing cast restoration is at least 84 months old, is not serviceable and cannot be repaired. The time requirement applies even if the existing cast restoration was not provided under this Contract.
- kk) Benefit for prefabricated stainless steel and resin crowns are a benefit only for covered dependent children who are under the age of 16, subject to any applicable Waiting Period or reduced Coinsurance which might apply. Prefabricated resin crowns are a benefit on anterior teeth only. Benefits for the replacement of a prefabricated crown are not a benefit within 36 months of the placement of an existing prefabricated crown.
- ll) No benefit will be provided for temporary or interim partial dentures. Charges for temporary partial dentures are chargeable to the patient.
- mm) Bone grafting when done in the same site as a tooth extraction, implant, apicoectomy or hemisection.

## **SUBROGATION**

Delta Dental is entitled to enforce by its direct suit, or as co-plaintiff with a Covered Person, the Covered Person's claim against any third party to the extent of Benefits paid for, or on behalf of, a Covered Person by Delta Dental. When Delta Dental provides benefit payments for injuries sustained by a Covered Person and the Covered Person subsequently obtains a settlement from a third party which includes such costs, the Covered Person is obligated to refund to Delta Dental the amount equal to the benefit payment made to, or on behalf of, the Covered Person.

## **APPEAL PROCESS**

A Covered Person has the right to appeal any adverse determination made on a claim, whether in whole or in part. An appeal request may 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 additional documentation in support of the appeal. A second-level or external appeal, in certain cases, may be available on qualified claims. For those cases that qualify for an Independent External Review, a Covered Person may submit a request in writing within 60

days of the First or Second Level Appeal decision to the Appeals Analyst at the address above. The request must include a completed External Review Request Form that includes a signed consent authorizing Delta Dental to disclose protected health information pertinent to the external review.

## HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your plan administrator has agreed to:

- a) Not use or further disclose health information protected under HIPAA (Protected Health Information (PHI)) other than as permitted or as required by law;
- b) Ensure that any agents who receive PHI agree to the same restrictions that apply to your employer;
- c) Not to use or disclose PHI for employment-related actions and decisions;
- d) Report to the Plan any non-compliant use or disclosure of PHI that your employer is aware of;
- e) Make PHI available for an individual participant's own access and provide participants with the ability to amend or correct their 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 appropriate separation between the Plan and the Plan Sponsor was established as required by HIPAA and is supported by reasonable and appropriate security controls;
- h) If possible, return or destroy all PHI received from the health Plan when no longer needed for its purpose;
- i) Implement administrative, physical and technical safeguards that protect the confidentiality, integrity, and availability of the electronic protected health information that is managed on behalf of the group health plan;
- j) Ensure that any agent to whom it provides this information agrees to implement security measures to protect the information; and
- k) Report to the health plan any security incident of which it becomes aware.

## GLOSSARY

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

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

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

**COMPLETED** means:

- For Root Canal Therapy: On 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.
- 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 benefit payment purposes, the date Completed will be considered as the date when a Covered Service is incurred.

**DEDUCTIBLE** means the portion of the Covered Amount for certain Covered Services which must be paid in full for each Covered Person before any Benefits are payable. The amount of the Deductible is shown on the Summary of Dental Plan Benefits. If there is a maximum amount that a family must pay in Deductibles that will also be shown on the Summary of Dental Plan Benefits.

**DENTAL INJURY** is an injury to a Sound Natural Tooth (other than a chewing injury) sustained while covered under the Contract, which is caused solely by a sudden violent act, or accident that could not be predicted in advance or avoided. A chewing injury is any injury that occurs during the act of biting or chewing regardless of whether the injury is caused by biting food or a foreign object.

**DENTIST** means an individual licensed to practice dentistry at the time and in the place Services are provided.

**DEPENDENT** means

- if coverage is elected, the Subscriber's lawful spouse, including common law spouse;
- if coverage is elected, a dependent child under the Dependent Age Limit shown on the Summary of Dental Plan Benefits;
- if coverage is elected, a dependent child who reaches the Dependent Age Limit stated on the Summary of Dental Plan Benefits, is incapable of self-support because of physical handicap or mental incapacity that began before reaching the Dependent Age Limit, and is dependent on the Subscriber. Delta Dental may annually request a copy of the court-ordered guardianship as proof of such handicap or incapacity and dependency. Upon failure to submit such required proof, or when the child is no longer incapacitated, coverage will terminate.

Eligible Dependent children include natural children, stepchildren, court-ordered guardianship, adopted children, and foster children, provided such children are dependent on the eligible Subscriber.

Persons in active military service will not be considered as eligible Dependents.

**EMERGENCY TREATMENT or EMERGENCY SERVICE**

means any necessary Service that is rendered as the direct result of an unforeseen occurrence or combination of circumstances that requires immediate, urgent action or remedy.

**EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES**

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

**FUNCTIONING NATURAL TOOTH:** A permanent (adult) Natural Tooth which is performing its normal role in the mastication (i.e. chewing) process in the Covered Person's upper or lower arch and which is opposed in the Covered Person's other arch by another Natural Tooth or prosthodontic (i.e. artificial) replacement. Third molars are not considered Functioning Natural Teeth.

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

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

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

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

**STARTED** means

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

**SUBSCRIBER** means a person enrolled in the plan who has paid their appropriate premium.

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

## 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.

Delta Dental is required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are committed to protecting your health information.

### **How We May Use and Disclose Health Information About You**

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

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

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

**To You and With Your Written Authorization:** We may disclose your health information to you in the manner and for the purposes described in the “Your Rights” section of this Notice. You may revoke your authorization in writing at any time. Your revocation will not affect any use or disclosure permitted by your prior authorization while it was in effect.

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

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

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

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

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

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

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

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

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

### **Your Rights Regarding Health Information About You**

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

#### **Your Right to Inspect and Copy Your Health Information:**

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

#### **Your Right to Amend Protected Health Information:**

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

#### **Your Right to an Accounting of Disclosures Made by Delta Dental:**

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

#### **Your Right to Request Restrictions on Uses and Disclosures:**

Although you have this right, Delta Dental is not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing.

#### **Your Right to Request Confidential Communications Through a Reasonable Alternative Means or at an Alternative Location:**

To request confidential communications, you must submit your request in writing. We are not required to agree to your request, unless such disclosure could cause you to be in danger.

#### **Your Right to a Paper Copy of this Notice:**

You may obtain additional paper copies of this Notice by sending us a written request. You may also obtain a copy of this Notice at our website [www.deltadentalco.com](http://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**

**Visit Delta Dental's Website at:**  
[www.deltadentalco.com](http://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