Delta Dental PPO
Maximum Allowable Charge (MAC) Plan

INSHORE BENEFITS
Group #W2884
Effective: August 1, 2022

Internal Group #W2881 - Option 4

DELTA DENTAL

Delta Dental PPO, Maximum Allowable Charge (MAC) Plan
Schedule of Benefits
For Group #W2884
INSHORE BENEFITS

Internal Group #W2881 - Option 4

This Schedule of Benefits should be read in conjunction with your Subscriber Benefit Booklet. Your Subscriber 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 Provider, you may have more out-of-pocket costs.**

Control Plan — Delta Dental of Colorado
Benefit Year — January 1st to December 31st

Table of Covered Services

	Delta Dental PPO™ Provider	**Delta Dental Premier® Provider**	***Non-Participating Provider**
Covered Services	**Plan Pays**	**Plan Pays**	**Plan Pays**
Diagnostic & Preventive Services			
Oral Exams and Cleanings	**100%** of the PPO Schedule of Allowances	**50%** of the PPO Schedule of Allowances	**50%** of the PPO Schedule of Allowances
X-Rays			
Sealants			
Fluoride Treatments			
Basic Services			
Basic Restorative (Fillings)	**80%** of the PPO Schedule of Allowances	**50%** of the PPO Schedule of Allowances	**50%** of the PPO Schedule of Allowances
Oral Surgery			
Endodontics (Root Canal Therapy)			
Periodontics (Gum Disease Treatment)			
Major Services			
Prosthodontics (Dentures, Bridges)	**50%** of the PPO Schedule of Allowances	**40%** of the PPO Schedule of Allowances	**40%** of the PPO Schedule of Allowances
Special Restorative (Crowns, Implants, and Onlays)			
Orthodontic Services (12 Month Waiting Period)			
Orthodontics (all ages)	**50%** of the PPO Schedule of Allowances	**50%** of the PPO Schedule of Allowances	**50%** of the PPO Schedule of Allowances

*** If you do not use a PPO Provider, and your provider charges more than the PPO Schedule of Allowances, you may be responsible for excess charges. If you see a Premier Provider, you are responsible for the difference between the PPO Schedule of Allowances and the fee from the Premier Maximum Plan Allowance. If you see a Non-Participating Provider, you are responsible for the difference between the PPO Schedule of Allowances and the full billed charges.**

Age

Type	**Age Limit**	**Coverage Thru**
Dependent Child	26	Month

Deductible (January 1st–December 31st)

Class	Type	Network	Amount
All Covered Classes Except D&P and Ortho	Individual coverage amount	PPO, Premier & Non-Participating	$50
All Covered Classes Except D&P and Ortho	Family coverage amount	PPO, Premier & Non-Participating	$150

Annual Maximum (January 1st–December 31st)

Class	Type	Network*	Amount
All Covered Classes Except Ortho	Individual coverage amount	PPO, Premier & Non-Participating	$1000
Orthodontic Classes	Individual Lifetime	PPO, Premier & Non-Participating	$1000

***There is only one annual maximum. It will be combined among PPO, Premier, and Non-Participating Providers.**

Enrollment Type

The enrollment type is Open Enrollment. Open Enrollment means a period of time each contract year occurring prior to the anniversary date during which Subscribers eligible to enroll may choose to enroll themselves and/or their eligible Dependents in the plan or change from one coverage option to another if the contract issued to the group permits them to do so. Coverage will become effective on the group's anniversary date.

Where two Subscribers who are spouses and are both eligible for coverage under this contract, they may be enrolled together or separately, but not both. Dependent children may only be enrolled under one parent. The term spouse includes a civil union partner.

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

PPO Participating Provider
Advantages of seeing a PPO provider include:
- Payment is based upon the PPO Schedule of Allowances, or the fee actually charged, whichever is less.
- Claim forms are submitted directly to Delta Dental by the providers.
- 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 Provider.

Premier Participating Provider (Non-PPO)
You have the option of seeing a Premier Provider, but you may incur additional out-of-pocket costs:
- Payment is based upon the PPO Schedule of Allowances, or the fee actually charged, whichever is less.
- Claim forms are submitted directly to Delta Dental by the Providers.
- You are responsible between the Premier Maximum Plan Allowance and the PPO Schedule of Allowances, any applicable deductible and coinsurance for covered procedures.

Non-Participating Provider (Non-PPO)
You have the option of seeing a Non-Participating Provider, but you may incur additional out-of-pocket costs:
- You may be responsible for payment in full to the Provider and for filing your claim with Delta Dental for reimbursement.
- You are responsible for the difference between the full fee charged by the provider and the PPO Schedule of Allowances, any applicable deductible and coinsurance covered procedures.

COVERED AMOUNT means
The lesser of the PPO Schedule of Allowances or the fee actually charged.

Colorado counties without PPO or Premier providers are Cheyenne, Crowley, Gilpin, Jackson, Kiowa, Saguache, San Juan, and Sedgwick.

Delta Dental of Colorado
Group Dental Plan

CONTACT US

Visit Delta Dental's website:
www.deltadentalco.com

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

Delta Dental of Colorado
PO Box 173803
Denver, CO 80217

Customer Service:
1-800-610-0201
customer_service@ddpco.com

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ELIGIBILITY

All eligible Subscribers and their Dependents who enroll will be covered on the Effective Date. All Subscribers will become eligible as determined by the employer group.

This Policy is effective at 12 a.m. on the Effective Date and will terminate at 11:59 p.m. on the date of termination.

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

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

Persons in active military service are not eligible Dependents.

Dependents of an eligible subscriber may enroll within 31 days of the following:

- The date the Subscriber becomes eligible to enroll. The effective date is that of the Subscriber.
- New Dependents must be enrolled within 31 days and will be covered the first of the following month. Newborns and adopted children will be covered on the date of birth or date of placement for adoption.
- The date the plan is amended to provide dependent coverage. The plan becomes effective on the first day of the month following this change.
- The date upon which they lose coverage through another source, if they show proof of loss. (Loss of coverage is any loss due to death, divorce, loss of job, or termination of benefits by the subscriber). The Effective Date will be the first day of the month following this change.

If not added within the 31-day timeframe, the Dependent can be added during the Open Enrollment period, if applicable.

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

How to Find a Provider

There are two easy ways to find out if your Provider is a Delta Dental PPO or Premier participating Provider.

1. **Visit our website at www.deltadentalco.com** or
2. **Call customer service** at 1-800-610-0201.

The network is subject to change. Please check on the status of your Provider before your next treatment.

You do not need to get approval before being treated. Before starting treatment that may cost $400 or more, you may request an estimate from Delta Dental. Pre-treatment estimates are not required.

BENEFITS/COVERAGE (What is Covered)

COVERED DENTAL SERVICES

DIAGNOSTIC & PREVENTIVE SERVICES

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

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

PROCEDURE	BENEFIT DESCRIPTION
Oral Exam (all exam types, except Limited Oral Exam — Problem Focused)	Two exams in a calendar year are covered. There is no separate benefit for diagnosis, treatment planning, or consultation by the treating Provider.
Limited Oral Exam — Problem Focused	Two limited exams in a calendar year are covered (in addition to oral exams).
Screenings	Two screenings in a calendar year are covered (in addition to oral exams)
Bitewing X-rays	Covered once in a calendar year or limited to the allowance for a full-mouth survey. Not separately benefited 6 months after full-mouth survey. Limit two bitewing images for patients under age 10.
Full-mouth Survey or Panoramic X-ray	Covered once in five calendar years.
Individual Periapical X-rays Intraoral Occlusal X-rays	Limited to the allowance for a full-mouth survey.
Dental Cleaning	Two cleanings or any procedure that includes any component of a cleaning in a calendar year are covered. For those with any condition(s) listed below, two additional cleanings (or any procedure that includes cleaning) will be provided during a calendar year. • Diabetes with documented gum conditions, • Pregnancy with documented gum conditions, • Cardiovascular disease with documented gum conditions, • Kidney failure with dialysis, and • Suppressed immune system due to chemotherapy or radiation treatment, HIV Positive status, Organ Transplant or stem cell (bone marrow) transplant.
Sealants or Preventive Resin Restoration	Covered one time per tooth in three calendar years. Allowed for the occlusal (chewing) surface of decay-free unrestored permanent molars. Covered for Dependent children through age 19. There is no separate benefit for preparation of the tooth or any other procedure associated with the sealant application.
Fluoride Treatment	Covered twice per calendar year, no age limitations.
Silver Diamine Fluoride	Covered twice per calendar year per tooth, no age limitations.
Caries Risk Assessment	Covered once per calendar year. Not covered under age 3.
Space Maintainer	Covered once per quadrant per lifetime through age 19 to maintain space left by prematurely lost baby back teeth. Distal shoe space maintainers covered through age 8.
Palliative Treatment	Covered as a separate benefit only if no other service is provided during the visit except an exam and/or X-rays.
Oral Pathology Lab Procedures	Covered with a pathology report.

BASIC SERVICES

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

PROCEDURE	BENEFIT DESCRIPTION
Amalgam Fillings (silver fillings) and Composite Resin (white plastic) Fillings	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing filling is allowed if at least five calendar years have passed since the existing filling was placed.
Interim Therapeutic Restoration	Covered once per tooth per lifetime for baby teeth.
Protective Filling	Covered once per calendar year per tooth for emergency relief of pain if no other restorative service is performed on the same tooth on the same date.
Pin Retention	Covered with a basic (amalgam or composite) filling. A benefit one time per filling.
Stainless Steel Crowns Resin Crowns	Covered once per calendar year per tooth when that tooth cannot be restored by a filling.

BASIC — ENDODONTIC SERVICES

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

Therapeutic Pulpotomy	Covered once per tooth per lifetime for baby teeth.
Root Canal Therapy	Covered once per tooth. Includes working and final X-rays, cultures, tests, local anesthesia, and routine follow-up care.
Repeat Root Canal Therapy	Covered if at least two calendar years have passed since the first root canal procedure on the same tooth was performed. Includes working and final X-rays, cultures, tests, local anesthesia, and routine follow-up care.
Apexification/Recalcification (apical closure/calcific repair of perforations, root resorption, etc.)	Covered once per tooth per lifetime. A course of treatment includes initial, interim, and final visits. Includes working and final X-rays, cultures, tests, local anesthesia, and routine follow-up care.
Apicoectomy	Covered once per root per two calendar years. Includes working and final X-rays, cultures, tests, local anesthesia, and routine follow-up care.
Retrograde Filling (per root)	Covered once per root per two calendar years. Includes working and final X-rays, cultures, tests, local anesthesia, and routine follow-up care.
Root Amputation (per root)	Includes working and final X-rays, cultures, tests, local anesthesia, and routine follow-up care.
Hemisection (includes any root removal)	Includes working and final X-rays, cultures, tests, local anesthesia, and routine follow-up care.

BASIC — PERIODONTIC SERVICES

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

Periodontal Scaling and Root Planing — Per Quadrant	Covered once per quadrant per two calendar years. If less than a full quadrant meets criteria for coverage, benefits will be based on the fee for a partial quadrant.
Scaling in the Presence of Gingival Inflammation	Scaling in the presence of gingival inflammation procedures, in combination with adult and dependent child cleanings or periodontal maintenance procedures, are limited to two per calendar year.
Periodontal Maintenance Procedures Following Active Therapy	Periodontal maintenance procedures, in combination with adult and dependent child cleanings or scaling in the presence of gingival inflammation procedures, are limited to four per calendar year.
Crown Lengthening — Hard Tissue, by Report	When performed on the same date as surgery to bone structures, crown preparation, or other restoration, service will not be reimbursed separately. Benefits are based on clinical review.

Osseous Surgery, Gingivectomy, Gingival Flap Procedure, Guided Tissue Regeneration (includes surgery and re-entry), Pedicle Soft Tissue Graft, Free Soft Tissue including donor site	Periodontal surgical procedures are covered once per quadrant per three calendar years. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Includes local anesthesia and routine post-operative care. Benefits are based on clinical review.

BASIC — ORAL SURGERY SERVICES

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

Extractions — Coronal Remnants Deciduous Tooth, Erupted Tooth, Exposed Root, Surgical Extractions of Teeth or Tooth Roots	Includes local anesthesia and routine post-operative care.
Oral Surgery Services	Includes but not limited to fistula closure, sinus perforation closure, tooth reimplantation, surgical access to expose teeth, biopsies, soft-tissue lesion removal, excision of bone tissue, excision of hyperplastic gum tissue, surgical incisions, and cyst removal. Includes local anesthesia and routine post-operative care. Benefits are based on clinical review.
Alveoloplasty	Included when performed on the same date as extractions and includes local anesthesia and routine post-operative care.

BASIC— PAIN MANAGEMENT SERVICES

General Anesthesia, Analgesia (Nitrous Oxide), I.V. Sedation	Only one type of anesthesia procedure per date of service is allowed as a separate benefit when provided for covered endodontics, periodontal surgery, surgical implant placement, and oral surgery procedures.

MAJOR — ADJUSTMENT AND REPAIR SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Re-cement Crowns, Inlays, and Onlays	Covered after six months from initial insertion and once per lifetime per Provider/Provider's office.
Repairs to Crowns	Benefits based on clinical review.
Re-cement Fixed Bridges	Covered after six months from initial insertion of fixed bridge and once per lifetime per Provider/Provider's office.
Repairs to Fixed Bridges	Benefits based on clinical review.

MAJOR — DENTURE ADJUSTMENT, REPAIR, RELINE, AND REBASE SERVICES

Denture Adjustments	Covered after six months from the insertion of the full or partial denture, and then not more than two adjustments per appliance per one calendar year.
Repairs to Full and Partial Dentures	Covered after six months from the insertion of the full or partial appliance.
Tissue Conditioning per Denture	Covered twice per three calendar years per appliance.
Relining Dentures or Rebasing Dentures	Relining or rebasing is covered at least six months after the initial insertion of a full or partial denture and then not more than once per three calendar years per appliance.

MAJOR — INLAY, ONLAY, VENEER, IMPLANT, AND CROWN SERVICES

Special Restorative: Buildups (which may or may not include a post) and laboratory-processed restorations (crowns, onlays, veneers) for treatment of tooth decay that 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.

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

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. Covered at the amalgam filling benefit level and frequency. Not covered for Dependent children under age 12.
Onlays, Crowns (single unit), Veneers	Covered once per seven calendar years for the same tooth. Not covered under age 12. Benefits based on clinical review.
Core (Crown) Buildup including any Pins, Post and Core	Covered when needed to retain a special restorative service or prosthodontic service and only when need is due to extensive loss of tooth structure caused by decay or fracture. Post and core is covered only for endodontically treated teeth. Covered only if seven calendar years have passed since the last buildup or post and core procedure for the same tooth. Not covered for Dependent children under age 12. Benefits based on clinical review.
Implants — Surgical Placement and Restoration	The placement of the surgical implant and placement of a crown, full or partial denture, or bridge over the implant, is covered once in seven calendar years for restorations involving the same tooth. This limitation includes any prior Special Restorative or Prosthodontic benefits for the same tooth. Not covered for Dependent children under age 16. Temporary appliances are not separately payable.
Bone Graft for Repair of Peri-implant Defect	Covered once per three calendar years for the same tooth. Benefits based on clinical review.
Bone Graft at Time of Implant Placement	Covered when performed on the same day as surgical implant placement once per seven calendar years for the same tooth.

MAJOR —PROSTHODONTIC SERVICES

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 teeth.

Fixed Bridges	Covered once per seven calendar years per individual unit and only if seven calendar years have passed since the last special restorative, prosthodontic, or implant benefit for the same tooth/teeth. Not covered for Dependent children under age 16.
Full Dentures	Covered once per seven calendar years per arch. Not covered within seven calendar years of benefit for a partial denture in the same arch. Personalized denture procedures, overdentures, or associated procedures are not covered.
Partial Dentures	Covered once per seven calendar years per arch. Includes any clasps and rests and all teeth. Metal-based partial dentures are not covered under age 16.
Temporary Removable Partial Dentures	Payable for children 16 years of age or under for missing anterior permanent teeth.
Occlusal Guard	Covered once per five calendar years for bruxism (grinding). Adjustments are covered once per year following six months of initial placement.

ORTHODONTIC SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Orthodontic Treatment	Orthodontics are defined as the services provided by a licensed Provider involving orthognathic surgery or appliance therapy for movement of teeth and post-treatment retention for treatment of malalignment of teeth and/or jaws including any related interceptive services.
Limitations on Orthodontic Benefits	a) No benefits will be provided for: • Replacement or repair of appliances. • Orthodontic care provided in the treatment of periodontal cases or cases involving treatment or repositioning of the temporomandibular joint or related conditions. b) Periodic orthodontic payments will end upon termination of treatment for any reason prior to completion of the case or upon termination of the covered person's eligibility. c) The initial orthodontic benefit payment for a comprehensive treatment plan of 13 months or more will be made in two payments. The first payment will be issued at time of banding or insertion. The second payment will be issued 12 months later. The final payment will be reduced by any other orthodontic benefits issued that applied to the orthodontic plan maximum. Only members eligible in the plan 12 months after initial banding or insertion will receive the final payment. d) The orthodontic payment benefit for treatment plans 12 months or less will be made in one payment at time of banding or insertion. This payment will be reduced by any other orthodontic benefits issued that applied to the plan's orthodontic maximum. e) For comprehensive orthodontic treatment in progress that began prior to eligibility in the plan, periodic payments will be reduced using applicable processing policies.

LIMITATIONS/EXCLUSIONS
(What Is Not Covered)
GENERAL LIMITATIONS – ALL SERVICES

a) Alternate Benefits — Often more than one service or supply can be used for treatment. In deciding the amount allowed on a claim, plan will consider other materials and methods of treatment. Payment will be limited to the Covered Amount for the least costly covered service that meets accepted standards of dental care as determined by Delta Dental. The covered person and their Provider may decide on a more costly treatment. Delta Dental will pay toward the cost of the selected procedure using the Coinsurance level shown on the Schedule of Benefits. Payment will be limited to the Covered Amount for the least costly treatment. **Only covered services are eligible to receive alternate benefits.**

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

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

d) Services are covered when provided by a person legally permitted to perform such services and are determined to be necessary and appropriate. Benefits will be based on the terms of this plan and Delta Dental's Processing Policies, even if no monies are paid.

e) Pre- and post-operative procedures are considered part of any associated covered service. Benefit will be limited to the Covered Amount for the covered service.

f) Local anesthesia is considered part of any associated covered service. Benefit will be limited to the Covered Amount for the covered service.

g) The Covered Amount for a covered service Started but not Completed will be limited to the amount determined by Delta Dental.

h) Allowance for an assistant surgeon, when determined by Delta Dental to be a covered service, will not exceed 20% of the surgeon's fee for the same covered service.

i) Services related to another category of covered services may be covered at the same percentage as the related category of covered services.

j) Covered services will not be compensated when delivered in response to injuries or conditions that are covered under worker's compensation or employer's liability laws.

k) Covered services will not be compensated when provided by any federal or state agency.

l) Covered services provided without cost by any city, county, or other political subdivision will not be compensated.

m) Covered services for which the person would not have to pay if not insured—such as those delivered to a family member or employee of the Provider—will not be compensated.

n) Any covered service Started when the person was not covered under this contract will not be compensated. This includes any service Started during an applicable waiting period.

o) Any covered service provided primarily for cosmetic purposes will not be compensated, except where an Alternate Benefit will be provided as set forth in this contract.

p) Porcelain or resin fused to metal onlays or inlays after the first molar are considered cosmetic. The allowance will be limited to the least costly covered service that meets accepted standards of dental care as determined by Delta Dental, and the patient is responsible for the remainder of the Provider's approved fee.

q) Covered services to treat tooth structure lost from wear, erosion, attrition, abrasion, or abfraction will not be compensated.

r) Covered services will not be compensated when delivered as a result of improper alignment, occlusion, or contour.

s) Covered services related to periodontal stabilization of teeth (splinting) will not be compensated.

t) Covered services will not be compensated when the patient's oral health will not improve due to an underlying condition.

u) Covered services will not be compensated when provided in anticipation of future need (***except*** covered preventive services).

v) Covered services for grafting procedures will not be compensated when completed in the mouth where teeth are not present.

w) Covered services for grafts of tissues from outside the mouth into the mouth will not be compensated.

x) Covered services not performed in accordance with Colorado state law will not be compensated.

y) Covered services will not be compensated if administered by any person other than a person licensed to perform them.

z) Covered services to treat any condition, other than an oral or dental disease, abnormality, or condition will not be compensated.

aa) Covered services to replace lost, stolen, or damaged items will not be compensated.

bb) Covered services to repair items altered by someone other than a Provider will not be compensated.

cc) Covered services for which charges would not have been made but for this coverage, except for services as provided under Medicaid, will not be compensated.

dd) Covered services will not be compensated when delivered as a result of self-injury.

ee) Covered Services for any grafting procedure when done in the same site as a tooth extraction, apicoectomy, or hemisection (except bone grafting specific to implant placement if noted in covered services) will not be compensated.
ff) Covered Services for bone graft, biologic materials, tissue regeneration with periradicular surgery and any related services will not be compensated.
gg) Covered services provided for treatment of teeth retained in relation to an overdenture will not be compensated.
hh) Any prosthodontic service provided within seven calendar years of special restorative services involving the same teeth will not be compensated.
ii) Any special restorative service provided within seven calendar years of fixed prosthodontic services involving the same teeth will not be compensated.
jj) Fixed and removable prosthodontic appliances (bridges and partials) will not be compensated in the same arch except when the fixed denture (bridge) replaces front teeth.

EXCLUSIONS

a) Athletic mouth guards, sleep apnea appliance and jaw-function services, bite registration or analysis, or any related services**.**
b) Conscious sedation and other patient management services.
c) Charges for prescribed drugs.
d) Any Experimental or Investigational treatment.
e) Hospital costs or any charges for use of any facility.
f) House/extended care facility call, hospital, or ambulatory surgical center call.
g) Interim complete dentures.
h) Implant/abutment supported interim fixed denture for edentulous arch.
i) Therapy for speech or the function of the tongue or face.
j) Coping used as a definitive restoration.
k) Anatomical crown exposure and any related services.
l) Pulpal regeneration and any related services.
m) Connector bar or pediatric partial denture and any related services.
n) Any orthodontic services not specifically included in Covered Services, above.
o) Treatment of any temporomandibular joint (TMJ) problems, including facial pain or any related conditions. Any related diagnostic, preventive, or treatment services.
p) Tomographic survey.
q) 3D photographic images.
r) Image capture and/or interpretation for cone beam, MRI, ultrasound, sailoendoscopy.
s) Implant index.
t) Sample collection.
u) Any vestibuloplasty.
v) Any maxillofacial prosthetics services.
w) Any surgical repositioning of teeth, osteoplasty, osteotomy, LeFort procedures.
x) Any complicated suturing and reconstruction services.
y) Any transplantation or re-implantation services.
z) Any placement of temporary anchorage device.
aa) Any harvest of bone.
bb) Any corticotomy.
cc) Precision attachment and any related services.
dd) Repair or reline of occlusal guard, sleep apnea appliance and any other related services.
ee) Teaching services.
ff) Completion of forms. Providing diagnostic information. Copying of records. Sales tax. Translation services.
gg) Missed/cancelled appointment charges.
hh) Preventive and plaque-control programs, including home care items.
ii) Provisional splinting.
jj) Internal and external bleaching.
kk) Any services not included in Covered Services.

MEMBER PAYMENTS RESPONSIBILITY

You must pay deductibles, amounts above the annual maximum, and your coinsurance. You must pay charges for services not covered under this plan. You may be responsible for some part of the premium.

CLAIM PROCEDURES (How to File a Claim)

If you are covered by more than one dental plan, you should file all of your claims with each plan within 12 months of the treatment date.

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

PRE-TREATMENT ESTIMATE

Before beginning a course of treatment, a description of that course of treatment may be submitted to Delta Dental. Delta Dental will provide an estimate of the benefits for the planned course of treatment. Delta Dental does not require pre-treatment estimates. However, Delta Dental offers this service in order to allow for treatment planning.

RIGHT TO EXAMINATION

Delta Dental shall have the right to examine the person for whom a claim is made. Such right shall exist so often as reasonably required while a claim is pending under the policy.

GENERAL POLICY PROVISIONS

AGREEMENT WITH STATE LAW

Any requirement in this contract that, on its effective date, is in conflict with the laws of the state in which any covered person lives is hereby changed to the minimum requirement of such laws.

ASSIGNMENT OF BENEFITS

You may assign any benefits of this policy to your dental Provider. You may revoke this assignment at any time by sending a written revocation to Delta Dental.

NON-DISCRIMINATION

With regard to participation in its networks, Delta Dental does not discriminate against any Provider acting in the scope of their license.

COORDINATION OF BENEFITS (COB)

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits. This is not a complete description of all of the coordination rules and procedures and does not change or replace the language contained in your insurance contract, which determines your benefits. For the complete listing of your policy's coordination of benefits provisions, please contact your group plan administrator or the state Division of Insurance.

Double Coverage

Family members may be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one group health plan, state law permits your carriers to follow a procedure called coordination of benefits (COB) to determine how much each should pay when you have a claim. The aim is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, contact your group plan administrator or your state insurance department for a full review of coordination of benefits requirements.

Primary or Secondary?

You will be asked to identify all the plans that cover family members. We need this information to determine whether we are "primary" or "secondary." The primary plan always pays first.

Any plan that does not contain your state's coordination of benefits rules will always be primary.

When This Plan is Primary

If you or a family member are covered under another plan in addition to this one, Delta Dental will be primary when:

Your Own Expenses

▪The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expenses

▪The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Dependent Child's Expenses

▪The claim is for the health care expenses of your Dependent child who is covered by this plan and

▪You are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule";
or

▪You are separated or divorced and you have informed us of a court decree that makes you responsible for the dependent child's health care expenses;
or

▪There is no court decree, but you have primary custody of the dependent child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits provided by your contract, just as if you had no other coverage.

How We Pay Claims When We Are Secondary

We will be secondary whenever the rules do not require us to be primary.

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid. An "allowable expense" is a health care service or expense covered by one of the plans, including copayments and deductibles.

▪If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the Provider, our combined payments will not be more than the contract calls for. Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO) usually have contracts with their Providers.

▪We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We will use any savings to pay the balance of any unpaid allowable expenses covered by either plan.

▪If the primary plan covers similar kinds of health care but allows expenses that we do not cover, we may pay for those expenses. We will not pay an amount the primary plan did not cover because you didn't follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, we will not pay the amount of the reduction, because it is not an allowable expense.

Questions about coordination of benefits?

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

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 disclose health information 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 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 access this information.

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

How We May Use and Disclose Health Information About You

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

1. To communicate with the provider 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 providers provide.

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

To You and With Your Written Authorization: We may disclose your health information to you in the manner and for the purposes described in the "Your Rights" section of this notice. You may revoke your authorization in writing at any time. Your revocation will not affect any use or disclosure permitted by your prior authorization while it was in effect. Without your written authorization, we may not use or disclose your protected health information to any person or for any reason not permitted by law. An authorization is required for uses and disclosures of protected health information for marketing purposes and disclosures that constitute a sale of protected health information. Any other uses and disclosures not specifically described in this notice will be made only with the individual's authorization.

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

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

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

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

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

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

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

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

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

Your Rights Regarding Health Information About You

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

- **Your Right to Inspect and Copy Your Health Information:** To inspect and copy such information, you must submit your request in writing. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request.
- **Your Right to Amend Protected Health Information:** You may request that Delta Dental change your health information, although we are not required to do so. If your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make your request in writing. You must also provide a reason for your request.
- **Your Right to an Accounting of Disclosures Made by Delta Dental:** You may request an accounting of disclosures made for purposes other than treatment, payment, health care operations, or made to you. You must submit your request in writing. Your request should specify a time period of up to six years and may not include dates before April 14, 2003. Delta Dental will provide the first accounting per 12-month period free of charge; we may charge you for additional reports.
- **Your Right to Request Restrictions on Uses and Disclosures:** Although you have this right, Delta Dental is not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing.
- **Your Right to Request Confidential Communications Through a Reasonable Alternative Means or at an Alternative Location:** To request confidential communications, you must submit your request in writing. We are not required to agree to your request, unless such disclosure could cause you to be in danger.
- **Your Right to a Paper Copy of this Notice:** You may obtain additional paper copies of this notice by sending us a written request. You may also obtain a copy of this notice at our website, www.deltadentalco.com.
- **Your Right to Opt Out of Fundraising Communications:** Delta Dental does not intend to contact you to raise funds, but if it does engage in fundraising, you have the right to opt-out of receiving any fundraising communications.
- **Your Right to Breach Notification:** You have the right to be notified of a breach of unsecured protected health information. Delta Dental will provide you the date and description of the information disclosed. You will be notified who the information was disclosed to if we are able. You will be notified by mail within 30 days from the date that we discover the breach.
- **Your Right to Obtain Additional Information or File a Complaint:** Send us a written request if you would like to have a more detailed explanation of these rights. Complaints about how we handle your health information should be submitted in writing. If you believe your privacy rights have been violated, you may file a complaint with the secretary of the Department of Health and Human Services. Delta Dental will not retaliate against you in any way if you choose to file a complaint with us or with the department.

Genetic Information Nondiscrimination Act: Delta Dental is prohibited from using or disclosing genetic information for underwriting purposes.

Changes to this Notice

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

Send Written Requests Regarding this Privacy Notice to:
Compliance Department
PO Box 5468
Denver, CO 80217-5468
Phone Number: 1-800-233-0860

TIME LIMIT ON CERTAIN DEFENSES

(a) After two years from the date of issue of this policy, the validity of this policy shall not be contested, except for non-payment of premiums, and no misstatements made by the applicant in order to acquire such policy shall be used to void the policy or to deny a claim for loss incurred after the expiration of such two-year period. However, if such statement was made in writing signed by the person making the statement and a copy of that writing is presented to the maker of the statement, such statement may be used by Delta Dental to avoid the policy or reduce benefits.

(b) No claim for loss incurred after one year from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(c) If this is an individual disability income insurance policy then no claim for loss incurred after two years from the date of issue of the policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

TERMINATION/NONRENEWAL/ CONTINUATION

A Subscriber's plan will terminate at the earliest of:

- The date Delta Dental of Colorado receives a written request to cancel. Coverage will end at the end of the month following notification or at the end of the month of the life-changing event. We reserve the right to recover any benefit payment made for dates of service after the terminate date.
- The date the Subscriber is not eligible for coverage under the terms of this policy.
- The date the benefits described in the Policy are terminated.
- When the required premium has not been paid (subject to the applicable grace period).
- When you commit fraud or intentional misrepresentation of material facts.
- The date the Subscriber enters full-time military service of any country.
- Upon the Subscriber's death.

For Delta Dental to remove a Dependent from the plan, Delta Dental must notify Subscriber of the termination. For Subscriber or Dependent to remove a Dependent from the plan, Subscriber must notify group and group must notify Delta Dental of the termination. The Effective Date of the change will be the end of the month in which the change was received. We reserve the right to recover any Benefits payments made for dates of service after the termination date.

Benefits for a Dependent ends on the last day of the month for the following life changing events:

- The date the Benefits described in the policy are terminated.
- The date the Dependent is not eligible for coverage under the terms of this policy.
- When the Dependent child no longer qualifies as a Dependent by definition.
- When legal custody of a dependent child placed for adoption is terminated.
- When the required premium has not been paid.
- Upon the Dependent's death.

EXTENDED COVERAGE
(Paying for Benefits after Termination)

Delta Dental Benefits will end if this Policy is terminated or if a person's coverage is cancelled. Delta Dental will cover no further services except as described below.

If a covered service started before coverage ends, but the covered service is completed after coverage ends, 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 as would have applied if the person's coverage were still in effect.
- Benefits will be paid only if the covered service is completed within 60 days after the date the person's coverage ended.
- Extended coverage benefits do not apply to orthodontic services.

No benefit will be paid if the covered service is started after coverage ends.

NONRENEWAL

Your company's Policy will automatically renew. If you don't want to participate in the plan at renewal, notify your employer. If your employer does not renew this Policy, the Policy will end on the last day before the renewal date. Delta Dental can non-renew this Policy by sending your employer written notice (either electronically or through the mail) at least 90 days before the renewal dates. If we do, you will receive notice and this Policy will end on the last day before the renewal date.

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.

APPEALS AND COMPLAINTS

Internal Appeal Process — First-level Appeals:

An adverse claim determination may be appealed within 180 days of the date of the original Explanation of Benefits by writing to:

Delta Dental of Colorado
Attn: Appeals Analyst
PO Box 172528
Denver, CO 80217-2528

A Subscriber may submit additional information in support of the appeal.

Appeals are reviewed by an impartial Provider of the same or similar specialty as would typically manage the case being reviewed or by a Delta Dental claims specialist. The reviewing Provider will not have been involved in the initial decision.

The decision will be sent to the Subscriber with the rationale for the decision. The decision will be made within 15 calendar days for pre-service denials. Post-service decisions will be made within 60 calendar days.

When submitting a first-level appeal, a Member may submit written comments, documents, records, and other material relating to the request for Benefits for the reviewer(s) to consider when conducting the review. For review of a Benefit denial due to a contractual exclusion, the Member shall provide evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply.

Internal Appeal Process — Second-level Appeals

If a denial is upheld at the first level, a Subscriber may request a second-level appeal. The request must be received within 30 days of the First-level appeal decision. Additional information may be submitted. Second-level appeals will be reviewed by an impartial Provider with the appropriate expertise. The reviewing Provider will not have been involved in the first appeal. The Subscriber, or a designated representative, may request to appear before the reviewer in person or may present by conference call.

A second-level appeal decision will be issued within seven days of the review meeting.

Internal Appeal Process — Expedited Appeals:

Subscribers may request an expedited appeal when the time for a standard review would seriously jeopardize the life or health of the Subscriber, would jeopardize the Subscriber's ability to regain maximum function, or, for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently.

Expedited review decisions will be issued within 72 hours.

Independent External Review:

Where Delta Dental makes an Adverse Determination and the Subscriber exhausts the internal appeals process, the Subscriber has the right to request an external review. Delta Dental will notify the Subscriber of the right, if any, to request an external review after the First-Level appeal.

Requests for an independent external review must be in writing. They must include a completed external review request form as specified by the Colorado Division of Insurance. The Subscriber must submit the request within four months of the completion or exhaustion of the internal appeals process. The internal appeals process is completed or exhausted upon Subscriber's receipt of notice of the adverse determination or upon Delta Dental's failure to comply with Colorado Revised Statues §§ 10-16-113, 10-16-113.5 or Colorado Insurance Regulations 4-2-17 or 4-2-21.

Subscriber may request expedited external review. All requests must be submitted to:

Delta Dental of Colorado
Attn: Appeals Analyst
PO Box 172528
Denver, CO 80217-2528

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

Delta Dental adheres to timeframes set forth by Colorado Regulation 4-2-21 in the processing of independent external reviews. Within 45 days after the receipt of the request for external review (72 hours for expedited external review), the external review entity shall deliver a written decision to the Subscriber, Delta Dental, the Provider, and the Commissioner.

INFORMATION ON POLICY AND RATE CHANGES

No change in your policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed on the policy. No agent has authority to change this policy or to waive any of its provisions except where approved by an officer of the insurer and evidenced by an endorsement on the policy or by rider or amendment to the policy signed by the insurer. Any such amendment that reduces or eliminates coverage shall have been either requested in writing or signed by your employer.

If there are changes to the information provided in this document, we will issue revised materials to you.

DEFINITIONS

ADVERSE DETERMINATION means a denial of: A preauthorization for a covered benefit; a request for benefits for an individual on the grounds that the treatment or covered benefit is not medically necessary, appropriate, effective, or efficient or is not provided in or at the appropriate health care setting or level of care; a request for benefits on the ground that treatment or service is experimental or investigational; or a benefit denied because the treatment is an excluded benefit and wherein the claimant presents evidence from a dental professional licensed pursuant to the Dental Practice Law of Colorado that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit.

ALTERNATE BENEFIT means the benefit allowed for the least costly, commonly accepted service that could be used to treat a dental condition for which a Member has selected a more costly treatment.

BENEFITS means those services covered pursuant to the terms of this plan. Benefits for all covered services are subject to the limitations and exclusions noted in this benefit booklet.

COINSURANCE means the percentage of a Covered Amount that the Member will pay. The Coinsurance for each type of covered service is determinable by subtracting the "Plan Pays" amount on the Declarations page from 100 percent.

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 the final appliance is first inserted in the mouth.
- For all other services: On the date the procedure is Started.

For claim payment purposes, the date Completed will be the date when a claim is incurred.

DEDUCTIBLE means the amount that must be paid by the Member before Delta Dental will make payment. The amount of the Deductible is shown on the Schedule of Benefits. If there is a limit to the deductible amount that a family must pay, that will also be shown.

DEPENDENT means:

- The Subscriber's lawful spouse, including civil union partner.
- Civil union partner must:
  - ❖ Be at least 18 years old.
  - ❖ Not be a partner in another civil union.
  - ❖ Not be married to another person.
  - ❖ Not be related to the Subscriber.
  - ❖ Have entered into a civil union based on the guidelines of Article 15 of Title 14, C.R.S. recognized pursuant to Colorado law.
- A child under the Dependent age limit shown on the Schedule of Benefits.
- A child who reaches the Dependent age limit stated on the Schedule of Benefits and is incapable of self-support because of physical or mental disabilities that began before reaching the Dependent age limit and is dependent on the Subscriber. Delta Dental may annually request proof of such disability and dependency. Failure to submit such proof will terminate coverage.

Eligible dependent children include natural children, stepchildren, children under court-ordered guardianship, adopted children, foster children, and children of a civil union partner or common law spouse.

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

Persons in active military service are not eligible Dependents.

EFFECTIVE DATE means the date coverage begins.

EMERGENCY TREATMENT or **EMERGENCY SERVICE** means any required service that is provided as the direct result of an unforeseen occurrence that requires immediate, urgent action.

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

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

MAXIMUM PLAN ALLOWANCE means the maximum allowable amount for a procedure as determined by Delta Dental. Delta Dental reviews the limits twice a year. Delta Dental reserves the right to increase or decrease fees for any procedure in its sole and absolute discretion.

MEMBER means any person — Subscriber or Dependent — eligible and enrolled for coverage under this plan.

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

POLICY means the agreement between Delta Dental and the applicant for the dental benefits plan, in its entirety, including any application documents, riders, and/or appendices.

POLICY TERM means the time from the Effective Date of the Policy until it is terminated.

POLICY YEAR is the 365 days beginning on the Effective Date of this Policy and each year after unless the Policy is terminated. The Policy Year is 366 days in a leap year.

PROVIDER means a person licensed to perform dental services.

STARTED means:

- For full dentures or partial dentures (removable partial dentures): The date the final impression is taken.
- For fixed bridges (fixed partial dentures), crowns, inlays, onlays, and other laboratory prepared restorations: The date the teeth are first prepared (i.e., drilled down) to receive the restoration.
- For root canal therapy: The date the pulp chamber is first opened.
- For periodontal surgery: The date the surgery is actually performed.
- For all other services: The date the service is performed.

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

CONTACT US

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

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

Delta Dental of Colorado
PO Box 173803
Denver, CO 80217

Customer Service:
1-800-610-0201
customer_service@ddpco.com