Delta Dental PPO Plan

Colorado Employer Benefit Trust
Group #W1039, W1040 and W1041
Revised: January 1, 2020

Delta Dental PPO
Schedule of Benefits
For Group #W1039
COLORADO EMPLOYER BENEFIT TRUST

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.**

Right Start 4 Kids℠
*This product enhancement provides coverage for children up to their 13th birthday at **100% of the PPO or Premier Provider's Allowable Fee** for Diagnostic & Preventive, Basic and Major Services only, with no deductible applied (up to the annual maximum and subject to the limitations and exclusions defined in the plan). The child must see a Delta Dental PPO or Delta Dental Premier Provider to receive the 100% coinsurance. If a Non-Participating Provider is seen, the plan's standard coinsurance levels (as shown in the chart below) will apply.*

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

	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%	100%	100%
X-Rays	100%	100%	100%
Sealants	100%	100%	100%
Fluoride Treatment	100%	100%	100%
Basic Services			
Basic Restorative (Fillings)	80%	80%	80%
Oral Surgery	80%	80%	80%
Endodontics (Root Canal Therapy)	80%	80%	80%
Periodontics (Gum Disease Treatment)	80%	80%	80%
Occlusal Guard	80%	80%	80%
Major Services			
Implants	50%	50%	50%
Prosthodontics (Dentures, Bridges)	50%	50%	50%
Special Restorative (Crowns, Onlays)	50%	50%	50%
Orthodontic Services			
Orthodontics (all ages)	50%	50%	50%

***Important: Non-Participating Providers are not prohibited from balance billing, even on Covered Services. On all claims with Non-Participating Providers, Subscribers and/or Dependents are responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the Provider. Participating Providers are held to contracted fees on all Covered Services and may only balance bill on procedures that are not Covered Services.**

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 and Non-PPO	$50
All Covered Classes Except D&P and Ortho	Family coverage amount	PPO and Non-PPO	$150

Maximum (January 1st - December 31st)

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

Enrollment Type

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

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

Under the Delta Dental PPO plan, 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 Provider's Allowable fee, or the fee actually charged, whichever is less.
- Claim forms are submitted directly to Delta Dental by the Providers.
- You are 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 costs:

- Payment is based upon the Premier Maximum Plan Allowance, 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.

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 non-participating Maximum Plan Allowance and the full fee charged by the Provider.
- Reimbursement is based on 70% of the Usual and Customary fees.

COVERED AMOUNT means

- For PPO Providers, the lesser of the PPO Provider's Allowable fee or the fee actually charged.
- For Premier Participating Providers, the lesser of the Premier Maximum Plan Allowance, or the fee actually charged.
- For all other Providers, the lesser of the Non-Participating Maximum Plan Allowance, 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 PPO
Schedule of Benefits
For Group #W1040
COLORADO EMPLOYER BENEFIT TRUST

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Right Start 4 Kids℠

*This product enhancement provides coverage for children up to their 13th birthday at **100% of the PPO or Premier Provider's Allowable Fee** for Diagnostic & Preventive, Basic and Major Services only, with no deductible applied (up to the annual maximum and subject to the limitations and exclusions defined in the plan). The child must see a Delta Dental PPO or Delta Dental Premier Provider to receive the 100% coinsurance. If a Non-Participating Provider is seen, the plan's standard coinsurance levels (as shown in the chart below) will apply.*

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

	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%	100%	100%
X-Rays	100%	100%	100%
Sealants	100%	100%	100%
Fluoride Treatment	100%	100%	100%
Basic Services			
Basic Restorative (Fillings)	80%	80%	80%
Oral Surgery	80%	80%	80%
Endodontics (Root Canal Therapy)	80%	80%	80%
Periodontics (Gum Disease Treatment)	80%	80%	80%
Occlusal Guard	80%	80%	80%
Major Services			
Implants	50%	50%	50%
Prosthodontics (Dentures, Bridges)	50%	50%	50%
Special Restorative (Crowns, Onlays)	50%	50%	50%
Orthodontic Services			
Orthodontics (child to age 19)	50%	50%	50%

***Important: Non-Participating Providers are not prohibited from balance billing, even on Covered Services. On all claims with Non-Participating Providers, Subscribers and/or Dependents are responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the Provider. Participating Providers are held to contracted fees on all Covered Services and may only balance bill on procedures that are not Covered Services.**

Age

Type	Age Limit	Coverage Thru
End Dependent Ortho	19	Month
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 and Non-PPO	$50
All Covered Classes Except D&P and Ortho	Family coverage amount	PPO and Non-PPO	$150

Maximum (January 1st - December 31st)

Class	Type	Network	Amount
All Covered Classes Except D&P and Ortho	Individual coverage amount	PPO and Non-PPO	$1500
Orthodontic Classes	Individual lifetime	PPO and Non-PPO	$1500

Enrollment Type

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

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

Under the Delta Dental PPO plan, 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 Provider's Allowable fee, or the fee actually charged, whichever is less.
- Claim forms are submitted directly to Delta Dental by the Providers.
- You are 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 costs:

- Payment is based upon the Premier Maximum Plan Allowance, 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.

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 non-participating Maximum Plan Allowance and the full fee charged by the Provider.
- Reimbursement is based on 50% of the Usual and Customary fees.

COVERED AMOUNT means

- For PPO Providers, the lesser of the PPO Provider's Allowable fee or the fee actually charged.
- For Premier Participating Providers, the lesser of the Premier Maximum Plan Allowance, or the fee actually charged.
- For all other Providers, the lesser of the Non-Participating Maximum Plan Allowance, or the fee actually charged.

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Delta Dental PPO
Schedule of Benefits
For Group #W1041
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Benefit Year - January 1st to December 31st

	PPO Provider	Delta Dental Premier Provider	*Non-Participating Provider
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X-Rays	100%	100%	100%
Sealants	100%	100%	100%
Fluoride Treatment	100%	100%	100%
Basic Services			
Basic Restorative (Fillings)	80%	80%	80%
Oral Surgery	80%	80%	80%
Endodontics (Root Canal Therapy)	80%	80%	80%
Periodontics (Gum Disease Treatment)	80%	80%	80%
Occlusal Guard	80%	80%	80%
Major Services			
Implants	50%	50%	50%
Prosthodontics (Dentures, Bridges)	50%	50%	50%
Special Restorative (Crowns, Onlays)	50%	50%	50%

Orthodontia is not a covered benefit.

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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	Individual coverage amount	PPO and Non-PPO	$50
All Covered Classes Except D&P	Family coverage amount	PPO and Non-PPO	$150

Maximum (January 1st - December 31st)

Class	Type	Network	Amount
All Covered Classes Except D&P	Individual coverage amount	PPO and Non-PPO	$1500

Enrollment Type

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- Claim forms are submitted directly to Delta Dental by the Providers.
- You are only responsible for any applicable deductible and coinsurance for covered procedures.

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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 non-participating Maximum Plan Allowance and the full fee charged by the Provider.
- Reimbursement is based on 50% of the Usual and Customary fees.

COVERED AMOUNT means

- For PPO Providers, the lesser of the PPO Provider's Allowable fee or the fee actually charged.
- For Premier Participating Providers, the lesser of the Premier Maximum Plan Allowance, or the fee actually charged.
- For all other Providers, the lesser of the Non-Participating Maximum Plan Allowance, or the fee actually charged.

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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
4582 South Ulster Street, Suite 800
Denver, CO 80237

Customer Service:
1-800-610-0201

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ELIGIBILITY

All eligible Subscribers and their dependents that enroll will be covered on the effective date. All Subscribers will become eligible as determined by the employer group.

This policy is effective at 12:00 a.m. on the date of enrollment and will terminate at 11:59 p.m. on the date of termination.

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 30 days of the following:

- The date the Subscriber becomes eligible to enroll. The effective date is that of the subscriber.
- New Dependents of qualifying event must be enrolled within 30 days and will be covered on the date of the event. Newborns and adopted children will be covered on the date of birth or date of placement for adoption.
- 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 date of the event.

If not added within the 30 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 Network Provider.

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

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

You need not obtain 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.

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

PROCEDURE	BENEFIT DESCRIPTION
Oral Exam (All exam types)	Two exams in a 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 exams in a calendar year are covered (in addition to Oral Exams).
Dental Cleaning	Two cleanings in a calendar year are covered. An adult cleaning is not covered for persons under age 14. For those with any condition(s) listed below, 2 additional cleanings (or any procedure that includes cleaning) will be provided during a calendar year. • Individuals with a history of previous definitive periodontal treatment, • Diabetes with documented gum conditions, • Pregnancy with documented gum conditions, • Cardiovascular disease with documented gum conditions, • Kidney failure with dialysis, and • Suppressed immune system due to chemotherapy or radiation treatment, HIV Positive status, Organ Transplant or stem cell (bone marrow) transplant.
Bitewing X-rays	Covered once in a calendar year.
Full Mouth Survey or Panoramic X-ray	Covered one time in 5 calendar years.
Individual Periapical X-rays **Intraoral Occlusal X-rays** **Extraoral X-rays**	Limited to the allowance for a full mouth survey or panoramic x-ray. If the fee meets or exceeds the allowance for a full mouth survey, it will be processed as a full mouth survey.
Sealants	Covered one time per tooth in a 36 month period. Allowed for the occlusal (chewing) surface of decay-free unrestored permanent molars. Covered for children through age 15. There is no separate benefit for preparation of the tooth or any other procedure associated with the sealant application.
Preventive Resin Restoration	Covered as a sealant above.
Fluoride Treatment	Covered twice in a calendar year for children through age 15.
Space Maintainer	Covered for children through age 13 to maintain space left by prematurely lost baby back teeth.
Adjunctive Services	Services related to another category of covered services will be covered at the same percentage as the related category of covered services.
Palliative Treatment	Covered as a separate benefit only if no other service is provided during the visit except an exam and/or x-rays.
Oral Pathology Lab Procedures	Covered with a pathology report.

BASIC SERVICES

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

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

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

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

PROCEDURE	BENEFIT DESCRIPTION
Amalgam Fillings (silver fillings)	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing amalgam filling is allowed if at least 1 calendar year has passed since the existing amalgam was placed.
Composite Resin (white plastic) Fillings	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing composite resin filling is allowed if at least 1 calendar year has passed since the filling was placed.
Stainless Steel Crowns Resin Crowns	Covered when the tooth cannot be restored by a filling and then 1 time in a calendar year.
Protective Filling	Covered if no other restorative service is performed on the same tooth on the same date. Not covered during a course of endodontic therapy.
Pin Retention	Covered with a basic (amalgam or composite) filling. A benefit one time per filling.
Extraction - Coronal Remnants Deciduous Tooth	Includes local anesthesia and routine post-operative care, which are not covered separately.
Extraction - Erupted Tooth or Exposed Root	Includes local anesthesia and routine post-operative care, which are not covered separately.
Therapeutic Pulpotomy	Covered for baby teeth.
Root Canal Therapy	Covered once per tooth. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Repeat Root Canal therapy	Covered if at least 2 calendar years have passed since the first root canal procedure on the same tooth was performed.
Apexification/Recalcification (apical closure/calcific repair of perforations, root resorption, etc.)	Covered once per tooth. A course of treatment includes initial, interim and final visits. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Apicoectomy	Covered once per root each per 24 months. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Retrograde Filling (per root)	Covered once per root each per 24 months. X-rays, cultures, tests, local anesthesia and routine follow-up care are not covered separately.
Root Amputation (per root)	X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Hemisection (includes any root removal)	X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Periodontal Scaling and Root Planing - Per Quadrant	Covered one time per quadrant of the mouth in any 2 calendar years.
Periodontal Maintenance Procedures Following Active Therapy	Periodontal maintenance procedures or any combination of periodontal maintenance procedures and prophylaxis (adult and child cleanings) are limited to 4 in a calendar year.
Gingivectomy	One periodontal surgical procedure is covered once per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Local anesthesia and routine post-operative care are not separately allowed as benefits.

Gingival Flap Procedure	One periodontal surgical procedure is covered once per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Root planing, local anesthesia and routine post-operative care are not separately covered.
Crown Lengthening - Hard Tissue, by Report	Not covered if performed on the same date as surgery to bone structures, crown preparation or other restoration.
Osseous Surgery, Guided Tissue Regeneration (includes surgery and re-entry), Pedicle Soft Tissue Graft, Free Soft Tissue Graft (including donor site)	One periodontal surgical procedure is covered once per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Surgical Extractions of Teeth or Tooth Roots	Local anesthesia and routine post-operative care are not separately allowed as benefits.
Oral Surgery Services	Includes fistula closure, sinus perforation closure, tooth reimplantation, surgical access to expose teeth, biopsies, soft-tissue lesion removal, excision of bone tissue, excision of hyperplastic gum tissue, surgical incisions, and cyst removal. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Alveoloplasty	Not allowed as a separate benefit when performed on the same date as extractions. Includes local anesthesia and routine post-operative care.
General Anesthesia **Analgesia (Nitrous Oxide)** **I.V. Sedation**	Only one type of anesthesia procedure per date of service is allowed as a separate benefit when provided for covered oral surgical procedures.
Cone Beam Xrays	Limited to one time in a 5 year calendar period.
Occlusal Guard & Occlusal Guard Adjustment	Removable dental appliance designed to minimize the effects of bruxism (grinding) and other occlusal factors. Covered once in a 5 calendar year period. Adjustments are covered once per 24 months.

MAJOR SERVICES

Special Restorative: Buildups (which may or may not include a post) and laboratory processed restorations (crowns, onlays) for treatment of tooth decay which results in visible destruction of hard tooth structure, or loss of tooth structure due to fracture, which cannot be restored with amalgam or composite restorations.

Prosthodontics: Services for construction or repair of fixed partial dentures (bridges), cast or acrylic removable partial dentures, acrylic complete dentures, and removable temporary partial dentures to replace completely extracted or avulsed natural permanent teeth.

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

PROCEDURE	BENEFIT DESCRIPTION
Re-Cement Crowns and Onlays	Covered after 6 months from initial insertion.
Repairs to Crowns	Subject to Delta Dental's consultant review.
Re-Cement Fixed Bridges	Covered after 6 months from initial insertion of fixed bridge.
Repairs to Fixed Bridges	Subject to Delta Dental's consultant review.
Denture Adjustments	Covered after 6 months from the insertion of the full or partial denture.
Repairs to Full and Partial Dentures	Covered after 6 months from the insertion of the full or partial denture.
Tissue Conditioning per Denture Unit	Covered two times in a 36 month period.
Relining Dentures **Rebasing Dentures**	Relining or rebasing is covered at least 6 months after the initial insertion of a full or partial denture and then not more than one time in a 36 month period.

Inlays	An alternate benefit allowance for an amalgam filling will be made for the same number of surfaces. Any difference in fee is chargeable to the patient. It will be covered if 5 calendar years have passed since the last placement. Not covered for children under age 12.
Crowns and Onlays	Covered when the tooth cannot be restored by an amalgam or composite filling and if more than 5 calendar years since the last placement. Not covered for children under age 12**.**
Core (Crown) Buildup including any Pins	Covered when needed to retain a crown or onlay and only when need is due to extensive loss of tooth structure caused by decay or fracture. Covered only if 5 calendar years have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 12.
Post and Core (in conjunction with a Crown or Onlay)	Covered for endodontically treated teeth. Must be needed to retain a crown or onlay, and only when necessary due to extensive loss of tooth structure caused by decay or fracture. Covered only if 5 calendar years have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 12.
Implants - Surgical Placement & Restoration	The placement of the surgical implant, and the placement of a crown, full or partial denture, or bridge over the implant, are covered once in 5 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 children under age 16.
Fixed Bridges	Initial fixed bridge is covered. Replacement of an existing fixed bridge is covered if the existing fixed bridge is more than 5 calendar years old, is not serviceable, and cannot be repaired, and there is no prior payment of covered Special Restorative or Prosthodontic benefits for the same tooth. Not covered for children under age 16.
Core (Bridge) Buildup including any Pins (in conjunction with a Bridge Abutment or a Fixed Bridge)	Covered when needed to retain a fixed bridge or endodontically treated teeth. Only when necessary due to extensive loss of tooth structure caused by decay or fracture. Covered only if 5 calendar years have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 16.
Full Dentures	Initial full dentures are covered. Replacement is covered after 5 calendar years from the last placement. Dentures must not be able to be repaired. Personalized dentures, overdentures or associated procedures are not covered.
Partial Dentures	Initial partial dentures are covered. Replacement is covered after 5 calendar years have elapsed since the last placement. Dentures must not be able to be repaired. Precision or semi-precision attachments are not covered. The benefit for a partial denture includes any clasps and rests and all teeth. Metal based partial dentures are not covered for children under age 16.
Temporary Removable Partial Dentures	Initial temporary removable partial dentures are covered to replace missing permanent front teeth. Replacement is covered only after 5 calendar years have elapsed since the last placement.

ORTHODONTIC SERVICES (Not a Covered Benefit for Group #W1041)

PROCEDURE	BENEFIT DESCRIPTION
Orthodontic Treatment	Orthodontics are defined as the services provided by a licensed Provider involving orthognathic surgery or appliance therapy for movement of teeth and post-treatment retention for treatment of malalignment of teeth and/or jaws including any related interceptive services.
Limitations on Orthodontic Benefits	a) No benefits will be provided for: • Replacement or repair of appliances. • Orthodontic care provided in the treatment of periodontal cases or cases involving treatment or repositioning of the temporomandibular joint or related conditions. b) Periodic Orthodontic payments will end upon termination of treatment for any reason prior to completion of the case, or upon termination of the Covered Person's eligibility. c) The initial orthodontic benefit payment for a comprehensive treatment plan of 13 months or more will be made in two (2) payments. The 1st payment will be issued at banding date or insertion. The 2nd payment will be issued 12 months later. The final payment will be reduced by any other orthodontic benefits issued that applied to the orthodontic plan maximum. Only members eligible in the Plan 12 months after initial banding or insertion will receive the final payment. d) The orthodontic payment benefit for treatment plans 12 months or less will be made in 1 payment at time of banding or insertion. This payment will be reduced by any other orthodontic benefits issued that applied to the plan's orthodontic maximum. e) For comprehensive orthodontic treatment in progress that began prior to eligibility in the plan, Delta Dental will reduce periodic payments using its applicable processing polices.

LIMITATIONS/EXCLUSIONS
(What Is Not Covered)

GENERAL LIMITATIONS – ALL SERVICES

a) Alternate Benefits - Often more than one service or supply can be used 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 his Provider may decide on a more costly treatment. Delta Dental will pay toward the cost of the selected procedure at the Coinsurance level shown on the Schedule of Benefits. Payment will be limited to the Covered Amount for the least costly treatment. **Only covered services will 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 will be covered at the same percentage as the related category of Covered Services.

EXCLUSIONS

a) Services for injuries or conditions which are covered under Worker's Compensation or employer's liability laws. Services provided by any federal or state agency. Services provided without cost by any city, county or other political subdivision. Any Services for which the person would not have to pay if not insured, except if such exclusion may be prohibited by law.

b) Any Service Started when the person was not covered under this Contract. This includes any Service Started during an applicable Waiting Period.

c) Services for treatment of birth or developmental defects, ***except*** Services within the mouth for treatment of a condition related to cleft lip and/or cleft palate

d) Any treatment provided primarily for cosmetic purposes. Veneers on teeth and facings or veneers placed on crowns or bridge units for teeth after the first molar will always be considered cosmetic. Delta Dental will limit their allowance to a Covered Service without facings or veneers and the patient is responsible for the remainder of the Provider's approved fee.

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

f) Services resulting from improper alignment, occlusion or contour.

g) Services related to periodontal stabilization of teeth (splinting).

h) Habit appliances, night guards, athletic mouth guards and jaw function services, bite registration or analysis, or any related services.

i) Patient management services (***except*** covered anesthetic services).

j) Charges for prescribed drugs.

k) Any Experimental or Investigational treatment.

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

m) Any treatment done in anticipation of future need (***except*** covered preventive services).

n) Hospital costs or any charges for use of any facility.

o) Any anesthesia service not included in Covered Services.

p) Grafts done in the mouth where teeth are not present.

q) Grafts of tissues from outside the mouth into the mouth.

r) Therapy for speech or the function of the tongue or face.

s) Orthodontic Services unless shown as covered on the Schedule of Benefits.

t) Treatment of any temporomandibular joint (TMJ) problems, including facial pain, or any related conditions. Any related diagnostic, preventive or treatment Services.

u) Services not performed in accordance with Colorado state law. Services by any person other than a person licensed to perform them. Services to treat any condition, other than an oral or dental disease, abnormality or condition.

v) Teaching services.

w) Completion of forms. Providing diagnostic information. Copying of other records.

x) Replacement of lost, stolen or damaged items.

y) Repair of items altered by someone other than a Provider.

z) Any Services not included in Covered Services.

aa) Services for which charges would not have been made but for this coverage, 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-injury.
ff) Provisional splinting.
gg) Bone grafting when done in the same site as a tooth extraction, apicoectomy or hemisection.
hh) Services provided for treatment of teeth retained in relation to an Overdenture.
ii) Any Prosthodontic service provided within 5 calendar years of Special Restorative services involving the same teeth.
jj) Any Special Restorative service provided within 5 calendar years of fixed Prosthodontic services involving the same teeth.
kk) Fixed and removable Prosthodontic appliances (bridges and partials) are not a benefit in the same arch except when the fixed denture (bridge) replaces front teeth. Allowance is limited to the allowance for the removable partial denture.

MEMBER PAYMENTS RESPONSIBILITY

You must pay deductibles, amounts above the annual maximum, amounts up to the out-of-pocket 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.

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

PRE-TREATMENT ESTIMATE

Before starting treatment that may cost $400 or more, you may request an estimate of what is covered. Pre-treatment estimates are not required.

RIGHT TO EXAMINATION

Delta Dental shall have the right and opportunity to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the policy.

GENERAL POLICY PROVISIONS

AGREEMENT WITH STATE LAW

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

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 his or her 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" 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 (COB) 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 which 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 ae 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 Child's Expenses
▪The claim is for the health care expenses of your 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 child's health care expenses;
or
▪there is no court decree, but you have primary custody of the 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, Ste 850
Denver, CO 80202
Phone Number: 303-894-7490 or 1-800-930-3745

SUBROGATION

Delta Dental may pursue, on behalf of the Group, on its own or with a Member, claims against third parties. If Delta Dental, on behalf of the Group, pays a claim for injuries to a Member and the Member settles with a third party for an amount that includes such costs, the Member must refund Delta Dental the amount equal to the benefit payment made to, or on behalf of, the Member. Delta Dental will refund the Group for the benefit payments made on behalf of Member.

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 fund raising 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 60 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:

Privacy Officer
PO Box 5468
Denver CO 80217-5468
Or You May Call: 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/CONTINUATION

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

- 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.

To remove a Dependent from the plan, the Subscriber must notify us 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 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.

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

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

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

Continued Health Coverage required by the State of Colorado

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

APPEALS AND COMPLAINTS

Internal Appeal Process - First Level Appeals:
A Subscriber may appeal an adverse claim decision within 180 days of the date of the original Explanation of Benefits by writing to:

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

A 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. 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 30 calendar days.

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.

INFORMATION ON POLICY AND RATE CHANGES

No change in your policy shall be valid until approved by an executive officer of Delta Dental of Colorado 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 CEBT.

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

DEFINITIONS

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

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

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

COMPLETED means:

- For Root Canal Therapy: The date the canals are permanently filled.
- For Fixed bridges (fixed partial dentures), Crowns, Inlays, Onlays, and other laboratory prepared restorations: On the date the restoration is cemented in place, regardless of the type of cement used.
- For Dentures and Partial Dentures (removable partial dentures): On the date that the final appliance is first inserted in the mouth.
- For all other Services, on the date the procedure is Started.

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

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

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

DEPENDENT means:

- The Subscriber's lawful spouse, including civil union partner.
- Civil Union partner must meet each of the requirements listed below:
  - ❖ They must be at least 18 years old.
  - ❖ They must be of the same or opposite sex.
  - ❖ They must not be a partner in another civil union.
  - ❖ They must not be married to another person.
  - ❖ They must not be related.
  - ❖ They must 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.
- An unmarried child who reaches the Dependent Age Limit stated on the Schedule of Benefits and is incapable of self-support because of physical or mental disabilities that began before reaching the Dependent Age Limit, and is dependent on the Subscriber. Delta Dental may annually request proof of such disability and dependency. Failure to submit such proof will terminate coverage.

Eligible children include the Eligible Employee's natural children, stepchildren, children under court-ordered guardianship, adopted children, foster children, and children of a civil union or domestic partner.

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

Persons in active military service are not eligible Dependents.

EFFECTIVE DATE is 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 A person who is eligible for coverage because his/her employer is a member of CEBT, and the person has met the eligibility requirements and eligibility period as determined by the employer; Employee may include elected or appointed officials of the employer who satisfy the employer's eligibility requirements and eligibility period.

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.

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

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

OUT-OF-POCKET MAXIMUM means the maximum amount you will have to pay for allowable covered expenses under this plan.

POLICY means the agreement between Delta Dental and the applicant. This Policy is the whole agreement between the parties and no change is allowed unless approved by the insurer.

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 practice dentistry.

STARTED means:

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

SUBSCRIBER means the person in whose name the membership under the policy is established. A person who elects continued coverage and for whom the monthly Premium is paid.

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
4582 South Ulster Street, Suite 800
Denver, CO 80237

Customer Service:
1-800-610-0201