

# **GROUP DENTAL PLAN**

For

## **UNIVERSITY OF COLORADO and AFFILIATES**

**University of Colorado #6451  
University of Colorado – Cobra #96451  
University of Colorado Hospital #6473  
University Physicians, Inc. #6457**

### **EPO 6A PLAN**

**Effective: July 1, 2010**

**APPENDIX A - PATIENT CO-PAYMENTS (EPO 6A)..... 1**

**ELIGIBILITY .....8**

    DEPENDENT ELIGIBILITY.....8

**TERMINATION OF COVERAGE .....8**

    EXTENDED COVERAGE .....8

**HOW TO USE THE DELTA DENTAL PLAN .....8**

**CLAIMS SUBMISSION.....8**

**EMERGENCY BENEFIT.....8**

**PRE-TREATMENT ESTIMATE .....8**

**COVERED DENTAL SERVICES .....9**

    DIAGNOSTIC, PREVENTIVE AND ADJUNCTIVE BENEFITS .....9

    BASIC BENEFITS .....9

    MAJOR BENEFITS .....9

    ORTHODONTICS .....10

**GENERAL LIMITATIONS - ALL SERVICES ..... 10**

**EXCLUSIONS ..... 10**

**COORDINATION OF BENEFITS..... 11**

**SUBROGATION ..... 11**

**APPEAL PROCESS..... 11**

**HIPAA..... 12**

**COBRA (CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985)..... 12**

**GLOSSARY ..... 12**

**DENTAL TERMINOLOGY..... 13**

**NOTICE OF PRIVACY PRACTICES..... 15**



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

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

**Control Plan** - Delta Dental of Colorado

**Plan Year** – The Plan Year will run from July 1<sup>st</sup> through June 30<sup>th</sup>

**PPO Dentist**

Covered Services -	CoPayment
<b>Diagnostic &amp; Preventive Benefits</b>	
<b>Diagnostic &amp; Preventive Services</b> - Used to diagnose and/or prevent dental abnormalities or disease (includes exams, cleanings and fluoride treatments)	<b>CoPayment is based on Appendix A – Patient Copayments EPO 6A</b>
<b>Dental X-Rays</b> - X-rays	<b>CoPayment is based on Appendix A – Patient Copayments EPO 6A</b>
<b>Sealants</b> - Used to prevent decay of pits and fissures of permanent back teeth	<b>CoPayment is based on Appendix A – Patient Copayments EPO 6A</b>
<b>Basic Benefits</b>	
<b>Oral Surgery Services</b> - Extractions and dental surgery, including preoperative and postoperative care	<b>CoPayment is based on Appendix A – Patient Copayments EPO 6A</b>
<b>Endodontic Services</b> - Used to treat teeth with diseased or damaged nerves (for example, root canals)	<b>CoPayment is based on Appendix A – Patient Copayments EPO 6A</b>
<b>Periodontic Services</b> - Used to treat diseases of the gums and supporting structures of the teeth	<b>CoPayment is based on Appendix A – Patient Copayments EPO 6A</b>
<b>Basic Restorative Services</b> - Used to repair teeth damaged by disease or injury (for example, fillings)	<b>CoPayment is based on Appendix A – Patient Copayments EPO 6A</b>
<b>Major Benefits</b>	
<b>Relines and Repairs</b> - Relines and repairs to bridges and dentures	<b>CoPayment is based on Appendix A – Patient Copayments EPO 6A</b>
<b>Special Restorative Services</b> - Used when teeth can't be restored with another filling material (for example, crowns)	<b>CoPayment is based on Appendix A – Patient Copayments EPO 6A</b>
<b>Prosthetic Services</b> - Used to replace missing natural teeth (for example, bridges and dentures)	<b>CoPayment is based on Appendix A – Patient Copayments EPO 6A</b>
<b>Orthodontic Benefits</b>	
<b>Orthodontic Services (no age limit)</b> - Used to correct malposed teeth and/or facial bones (for example, braces)	<b>CoPayment is based on Appendix A – Patient Copayments EPO 6A</b>

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

**Child Dependent Age Limit is to the end of the month in which they attain age 27.**

Also eligible are your spouse, common law spouse or Same Gender Domestic Partner (SGDP) and your eligible dependent children to the end of the month in which they turn the dependent age shown above.

**Maximum Payment** - \$2,000 Individual Plan Year Maximum on Diagnostic & Preventive, Basic, and Major Benefits. Delta Dental's payment for Orthodontic Benefits will not exceed a lifetime maximum of \$4,000 per eligible person.

**Deductible** - None.

**Enrollment Types:**

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

**Tied-To-Medical.** The medical and Delta Dental plans are offered as a package. Employees enrolled in the medical plan are automatically enrolled in a dental plan. Employees may elect dental coverage for any dependents whether or not they are enrolled in the medical plan.

Colorado counties without PPO Providers are, Baca, Bent, Cheyenne, Costilla, Crowley, Delta, Elbert, Gilpin, Gunnison, Hinsdale, Jackson, Kiowa, Lake, Mineral, Moffat, Ouray, Pitkin, Prowers, Rio Blanco, Saguache, San Juan, San Miguel, Sedgwick, Washington and Yuma.

Where two Employees who are spouses and are both eligible for coverage under this contract, they may be enrolled together or separately, but not both. Dependent children may only be enrolled under one parent.

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

### DIAGNOSTIC SERVICES

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

### PREVENTIVE

<b>Code</b>	<b>Description</b>	<b>Co-Pay</b>
D1110	Prophylaxis - adult	No Cost
D1120	Prophylaxis - child to age 14	No Cost
D1203	Fluoride treatment - excluding prophylaxis - child	No Cost
D1206	Fluoride Varnish – therapeutic application for moderate to high caries risk patients	No Cost
D1351	Sealant - per tooth - child	No Cost
D1510	Space maintainer-fixed unilateral	No Cost
D1515	Space maintainer-fixed bilateral	No Cost
D1520	Space maintainer - removable unilateral	No Cost
D1525	Space maintainer - removable bilateral	No Cost

## **ADJUNCTIVE GENERAL**

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

## **BASIC RESTORATIVE**

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

## **ENDODONTICS**

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

## **ORAL SURGERY**

<b><u>Code</u></b>	<b><u>Description</u></b>	<b><u>Co-Pay</u></b>
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$ 39.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$ 75.00
D7220	Removal of impacted tooth soft tissue	\$ 88.00
D7230	Removal of impacted tooth partially bony	\$107.00
D7240	Removal of impacted tooth completely bony	\$128.00
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications	\$ 151.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$ 83.00
D7285	Biopsy of oral tissue - hard (bone, tooth)	\$109.00
D7286	Biopsy of oral tissue - soft (all others)	\$ 64.00
D7310	Alveoloplasty in conjunction with extractions - per quadrant	\$ 63.00
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	\$ 88.00
D7471	Removal of lateral exostosis - (maxilla-upper or mandible-lower)	\$ 128.00
D7472	Removal of torus palatinus	\$ 132.00
D7473	Removal of torus mandibularis	\$ 142.00
D7510	Incision and drainage of abscess intraoral soft tissue	\$ 48.00
D7960	Frenulectomy (frenectomy or frenotomy) separate procedure	\$ 96.00

## **PERIODONTICS**

<b><u>Code</u></b>	<b><u>Description</u></b>	<b><u>Co-Pay</u></b>
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	\$ 117.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	\$ 39.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	\$ 156.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	\$ 132.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	\$ 334.00
D4261	Osseous surgery (including flap entry and closure) -one to three contiguous teeth or bounded teeth spaces per quadrant	\$289.00
D4263	Bone replacement graft-first site in quadrant	\$120.00
D4264	Bone replacement graft-each additional site in quadrant	\$ 60.00
D4271	Free soft tissue graft procedure (including donor site surgery)	\$234.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	\$ 70.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	\$ 50.00
D4910	Periodontal maintenance procedures following active therapy (periodontal prophylaxis)	\$ 40.00

## **SPECIAL RESTORATIVE**

<b><u>Code</u></b>	<b><u>Description</u></b>	<b><u>Co-Pay</u></b>
D2520	Inlay-metallic-2 surfaces	\$267.00
D2530	Inlay-metallic-3 or more surfaces	\$301.00
D2543	Onlay-metallic three surfaces	\$350.00
D2544	Onlay-metallic-four or more surfaces	\$369.00
D2710	Crown-resin-based composite (indirect)	\$160.00
D2740	Crown-porcelain/ceramic substrate	\$398.00
D2750	Crown-porcelain fused to high noble metal	\$383.00
D2751	Crown-porcelain fused to predominantly base metal	\$334.00
D2752	Crown-porcelain fused to noble metal	\$370.00
D2780	Crown-3/4 cast high noble metal	\$364.00
D2781	Crown-3/4 cast predominantly base metal	\$310.00
D2782	Crown-3/4 cast noble metal	\$337.00
D2790	Crown-full cast high noble metal	\$383.00
D2791	Crown-full cast predominantly base metal	\$320.00

## **SPECIAL RESTORATIVE (Cont.)**

<b><u>Code</u></b>	<b><u>Description</u></b>	<b><u>Co-Pay</u></b>
D2792	Crown-full cast noble metal	\$366.00
D2910	Recement inlay, only or partial coverage restoration	\$ 22.00
D2920	Recement crown	\$ 27.00
D2950	Crown buildup (substructure) including any pins	\$ 75.00
D2952	Post and core in addition to crown, indirectly fabricated	\$109.00
D2953	Each additional indirectly fabricated post-same tooth	\$ 16.00
D2954	Prefabricated post and core in addition to crown	\$ 89.00
D2957	Each additional prefabricated post-same tooth	\$ 13.00
D2961	Labial veneer (resin laminate) laboratory	\$ 225.00
D2962	Labial veneer (porcelain laminate) laboratory	\$ 289.00

## **PROSTHODONTICS**

<b><u>Code</u></b>	<b><u>Description</u></b>	<b><u>Co-Pay</u></b>
D5110	Complete denture, (maxillary -upper)	\$ 555.00
D5120	Complete denture, (mandibular- lower)	\$ 555.00
D5130	Immediate denture, (maxillary -upper)	\$569.00
D5140	Immediate denture, (mandibular- lower)	\$569.00
D5211	Upper partial denture - resin base (including any conventional clasps, rests and teeth)	\$ 374.00
D5212	Lower partial denture - resin base (including any conventional clasps, rests and teeth)	\$ 374.00
D5213	Upper partial denture - metal base with resin saddles (including any conventional clasps, rests and teeth)	\$ 546.00
D5214	Lower partial denture - metal base with resin saddles (including any conventional clasps, rests and teeth)	\$ 546.00
D5410	Adjust complete denture upper	\$ 22.00
D5411	Adjust complete denture lower	\$ 22.00
D5421	Adjust partial denture - upper	\$ 22.00
D5422	Adjust partial denture - lower	\$ 22.00
D5510	Repair broken complete denture base	\$ 64.00
D5520	Replace missing/broken tooth complete denture (each tooth)	\$ 54.00
D5610	Repair resin saddle or base partial denture	\$ 52.00
D5620	Repair cast framework partial denture	\$ 78.00
D5630	Repair/replace broken clasp partial denture	\$ 78.00

**PROSTHODONTICS (Cont.)**

<b><u>Code</u></b>	<b><u>Description</u></b>	<b><u>Co-Pay</u></b>
D5640	Replace tooth on partial denture per tooth	\$ 54.00
D5650	Add tooth to existing partial denture	\$ 55.00
D5660	Add clasp to existing partial denture	\$ 70.00
D5710	Rebase upper complete denture	\$167.00
D5711	Rebase lower complete denture	\$167.00
D5720	Rebase upper partial denture	\$160.00
D5721	Rebase lower partial denture	\$160.00
D5730	Reline complete upper denture (chairside)	\$ 77.00
D5731	Reline complete lower denture (chairside)	\$ 77.00
D5740	Reline upper partial denture (chairside)	\$ 83.00
D5741	Reline lower partial denture (chairside)	\$ 83.00
D5750	Reline complete upper denture (laboratory)	\$137.00
D5751	Reline complete lower denture (laboratory)	\$137.00
D5760	Reline upper partial denture (laboratory)	\$130.00
D5761	Reline lower partial denture (laboratory)	\$130.00
D5850	Tissue conditioning upper denture	\$ 46.00
D5851	Tissue conditioning lower denture	\$ 46.00
D6210	Pontic - cast high noble metal	\$365.00
D6211	Pontic - cast predominantly base metal	\$317.00
D6212	Pontic - cast noble metal	\$327.00
D6240	Pontic - porcelain fused to high noble metal	\$372.00
D6241	Pontic - porcelain fused to predominantly base metal	\$336.00
D6242	Pontic - porcelain fused to noble metal	\$354.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis	\$164.00
D6750	Crown - porcelain fused to high noble metal	\$376.00
D6751	Crown - porcelain fused to predominantly base metal	\$337.00
D6752	Crown - porcelain fused to noble metal	\$359.00
D6780	Crown - 3/4 cast high noble metal	\$350.00
D6790	Crown - full cast high noble metal	\$370.00
D6791	Crown - full cast predominantly base metal	\$326.00
D6792	Crown - full cast noble metal	\$362.00
D6930	Recement fixed partial denture	\$ 47.00
D6940	Stress breaker	\$ 83.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	\$134.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer	\$102.00
D6973	Core build up for retainer, including any pins	\$ 86.00
D6976	Each additional cast post-same tooth	\$ 23.00
D6977	Each additional prefabricated post-same tooth	\$ 18.00
D9120	Fixed partial denture sectioning	\$ 15.00

## **ORTHODONTICS**

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

**The Summary of Dental Plan Benefits for your Group Dental Plan is issued separately and is hereby incorporated into this book.**

**ELIGIBILITY**

All eligible employees and their dependents who enroll will be covered on the effective date. All new employees will become effective on the day eligibility has been established by the employer. Your Dependents who are covered are your spouse, common law spouse or SGDP and your eligible dependent children up to the date shown on the Summary of Dental Plan Benefits.

**DEPENDENT ELIGIBILITY**

Eligible dependents may be enrolled for coverage within 31 days of the latest of the following dates:

- The date the Employee becomes eligible to enroll if he has eligible Dependents on that date. Coverage for eligible Dependents becomes effective on the date the Employee's coverage becomes effective.
- The date the Employee first acquires an eligible Dependent. Coverage becomes effective on the first day of the month following this change.
- Newly acquired dependents must be added within 31 days of birth or acquisition or within one month of the date the child reaches age 3.
- Any eligible dependents that suffer involuntary loss of coverage through another source will be allowed to enroll within 31 days of the loss of coverage with satisfactory proof.

**TERMINATION OF COVERAGE**

Coverage will terminate at the earliest of:

- The last day of the month Delta Dental receives a written request to terminate coverage;
- The last day of the month the Covered Person is no longer eligible for coverage;
- The date the Contract terminates;
- The end of the period for which Premium is paid;
- The date the Covered Person enters full-time military service of any country; or
- As to any Dependent, the date the person no longer qualifies as a Dependent and loses their Dependent status. Loss of Dependent status can occur for many different reasons, and your employer may not know when this happens. Therefore, you are required to notify your employer within 60 days of the event or the loss of coverage, whichever is later.

**EXTENDED COVERAGE**

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

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

- No benefit is payable if the Covered Service is Started after the day the Person's coverage ends.
- Benefits are payable only in the amount that would have been payable and subject to the same terms and conditions of the Contract that would have applied, if the Person's coverage was still in effect.

- Benefits are payable only if the Covered Service is Completed within 60 days after the date the Person's coverage ended.

**HOW TO USE THE DELTA DENTAL PLAN**

**Under the EPO Plan, you must visit a Colorado PPO Participating Dentist in order to receive benefits.**

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

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

**How to Find a Dentist**

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

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

**Integrated Voice Response (IVR):** Delta Dental's IVR allows you to call and request a listing of Dentists in your area and receive it by mail or fax. Call (303) 741-9305 or (800) 610-0201 and follow the prompts.

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

**CLAIMS SUBMISSION**

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

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

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

**EMERGENCY BENEFIT**

In the event of an out-of-state dental emergency, this plan will pay dental expenses incurred up to a maximum of \$50.00 based on appeal of the claim.

**PRE-TREATMENT ESTIMATE**

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

## **COVERED DENTAL SERVICES DIAGNOSTIC, PREVENTIVE AND ADJUNCTIVE BENEFITS**

**DIAGNOSTIC, PREVENTIVE AND ADJUNCTIVE BENEFITS.** The Covered Person is responsible for the co-payment listed in the Co-Payment Appendix for each Covered Service.

**Diagnostic** – certain Services performed to assist the Dentist in evaluating the existing conditions and determining the dental care required.

- Oral Exams – to include initial, periodic, or emergency
- Dental X-Rays – to include complete (full mouth) series, single x-rays, or bitewings.

**Preventive** – certain Services performed to prevent the occurrence of dental abnormalities or disease.

- Dental Cleaning – to include removal of all deposits and/or stains, and polishing as a single complete service.

**Adjunctive** – certain additional Services including emergency palliative treatment performed as a temporary measure that does not affect a definite cure.

### **Limitations on Diagnostic, Preventive and Adjunctive Benefits**

- a) Benefits for oral examinations will not be provided more than twice in any plan year. Diagnosis, treatment planning or consultation by the treating Dentist (or other person legally permitted to perform such Services by authority of license), are considered components of a complete oral examination.
- b) Benefits for cleanings (adult and child), and/or any procedure that includes any component of cleaning, will not be provided more than twice in any plan year. For payment purposes, an adult cleaning is not a benefit for persons under age 14. For individuals with the conditions listed below, 2 additional cleanings (or any procedure that includes a component) will be provided during any plan year
  - People who are diabetic and have documented periodontal (gum) conditions or;
  - Women who are pregnant and have documented periodontal (gum) conditions or;
  - People with cardiovascular disease who have documented periodontal (gum) conditions or;
  - People with kidney failure or who are undergoing dialysis and;
  - People who have an immune system which is suppressed because of chemotherapy or radiation treatment, HIV Positive status, Organ Transplant, or stem cell (bone marrow) transplant.
- c) Topical fluoride application is a benefit only through age 15 and only once in a plan year.
- d) Benefit for full mouth x-rays is made only after 60 months have elapsed following any prior provision of payment for full mouth x-rays under any Delta Dental plan unless documentation of special need is provided. Benefit for supplementary bitewing individual x-rays is provided once every 12 months while the patient is under any Delta Dental plan. A panoramic survey (which may include bitewing x-rays and/or periapical x-rays) is considered a full mouth x-ray for purposes of this Contract. Total allowance for individual periapical x-rays, intraoral occlusal x-rays, extraoral x-rays and/or bitewing x-rays performed on the same day will not exceed the allowance for full mouth x-rays.

- e) Benefit for space maintainers will only be made for appliances to maintain space for eruption of permanent posterior teeth in cases of premature loss of primary (deciduous) teeth through age 13.
- f) Benefits for sealants are limited to one time per tooth in any 36 consecutive month period. Benefit is allowed only for the occlusal surface of decay-free and previously unrestored permanent molars for children through age 14. There is no separate benefit for preparation or conditioning of the tooth or any other procedure associated with the sealant application.

## **BASIC BENEFITS**

**BASIC BENEFITS.** The Covered Person is responsible for the co-payment listed in the Co-Payment Appendix for each Covered Service.

**Basic Restorative** - fillings (metal) or resin-based composite fillings (white/plastic) and preformed shell crowns for treatment of:

- 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 gums and bone supporting teeth.

### **Limitations on Basic Benefits**

- a) Benefit for the same Covered Basic Restorative Service will not be provided more than once in any 12-month period.
- b) No Benefits will be provided for treatment of teeth retained in relation to an overdenture.
- c) Benefit for the same Covered Surgical Periodontic Services will not be provided more than once in any 36-month period. Benefit for the same Covered Non-Surgical Periodontic Services will not be provided more than once in any 24-month period.
- d) Benefit for pulpotomy/pulpectomy will be made only for primary (deciduous) teeth.
- e) Periodontal maintenance procedures which include any component of cleaning are subject to the cleaning limitations outlined in Diagnostic, Preventive and Adjunctive Benefits.
- f) A course of treatment for apexification/recalcification (initial, interim, and final visits) is a benefit once per tooth.

## **MAJOR BENEFITS**

**MAJOR BENEFITS.** The Covered Person is responsible for the co-payment listed in the Co-Payment Appendix for each Covered Service.

**Special Restorative** - crowns, jackets, cast, fused or other laboratory processed restorations (except preformed shell crowns) for treatment of:

- decay which result in visible destruction of hard tooth structure or
- loss of tooth structure due to fracture which cannot be restored with amalgam or resin-based composite fillings.

**Other Special Restorative** - buildups (which may or may not include a post) for treatment of:

- decay which result in visible destruction of hard tooth structure or
- loss of tooth structure due to fracture which cannot be restored with amalgam or resin-based composite fillings.

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

**Limitations on Major Benefits - Special Restorative and Other Special Restorative**

- a) When two or more similar restorations are used to restore a tooth, allowance will not exceed the Covered Amount for the most inclusive Covered Service.
- b) Benefit for placement of Special Restorative Services will not be provided more than once in any 60-month period involving restorations of the same tooth. This includes any prior provision of Covered Prosthodontic Services involving the same teeth.
- c) Benefit for placement of Other Special Restorative Services will not be provided more than once in any 60-month period involving restorations of the same tooth.
- d) Any laboratory processed Special Restorative Service or Other Special Restorative Service (except preformed shell crowns) is not a benefit for children under the age of 12.
- e) No Benefits will be provided for treatment of teeth retained in relation to an overdenture.

**Limitations on Major Benefits - Prosthodontic**

- a) Benefit for replacement of prosthodontic appliances will not be provided more than once in any 60-month period. For removable partial dentures, the 60-month time limitation is not applicable when there is loss of an anchor tooth.
- b) Benefit for placement of prosthodontic Services will not be provided more than once in any 60-month period involving restorations of the same tooth. This includes any prior benefits of Special Restorative Services involving the same teeth.
- c) Removable temporary partial dentures are a benefit to replace missing permanent anterior teeth.
- d) Fixed bridges (fixed partial dentures) and/or cast metal framework partial dentures (removable partial dentures) are not a benefit for persons under age 16.
- e) Fixed and removable prosthodontic appliances are not a benefit in the same arch. Allowance will be limited to the allowance for a removable appliance.
- f) Benefit for reline or rebase of a prosthodontic appliance will be made only once in any 36-month period. Reline or rebase of a prosthodontic appliance at the time of insertion and/or within 6 months following insertion by the same Dentist is considered a component of the appliance and separate payment will not be made for such reline or rebase. Reline or rebase of an immediate denture is a covered benefit at any time, subject to the one in 36-month limitation.

**ORTHODONTICS**

**ORTHODONTIC BENEFITS.** The Covered Person is responsible for the amount listed on the Copayment Appendix sheet for each Covered Service.

Orthodontics are defined as the services provided by a licensed Dentist involving orthognathic surgery or appliance therapy for movement of teeth and post-treatment retention for treatment of malalignment of teeth and/or jaws including any related interceptive services. (Extraction of teeth is covered under Oral Surgery Benefits.)

**Limitations on Orthodontic Benefits**

- a) No benefits will be provided for:
  - Replacement or repair of appliances.
  - Orthodontic care provided in the treatment of periodontal cases or cases involving treatment or repositioning of the temporomandibular joint or related conditions.
- b) Periodic Orthodontic payments will end upon termination of treatment for any reason prior to completion of the case, or upon termination of the Covered Person's eligibility.
- c) For an Orthodontic treatment plan started prior to the eligibility date of the patient, Delta Dental will begin periodic payments with the first payment due following the patient eligibility date. The maximum benefit will be determined based upon the prior carrier's payment history.

**GENERAL LIMITATIONS - ALL SERVICES**

- a) Completed dental Services are Benefits when provided by a Dentist (or other person legally permitted to perform such Services by authority of license) and are determined under the standards of generally accepted dental practice to be Necessary and appropriate. Benefits will be determined (even if no monies are paid) based on the terms of the Contract and Delta Dental's Processing Guidelines.
- b) 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.
- c) Local anesthesia is considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.
- d) A temporary dental Service is considered part of any complete Covered Service. Benefits will be limited to the Covered Amount for the complete Covered Service, unless the temporary Service is specifically included as a Covered Service of this Contract.

**EXCLUSIONS**

- a) Services for injuries or conditions which are compensable under Worker's Compensation or employer's liability laws, or Services which are provided to the Covered Person by any federal or state government agency or are provided without cost to the Covered Person by any municipality, county or other political subdivision, or any Services for which the Covered Person would have no obligation to pay in absence of this coverage, except as such exclusion may be prohibited by law.
- b) Any Covered Service Started when the person was not eligible for such Service under this Contract.
- c) Services for treatment of congenital (present at birth) or developmental (following birth) malformations, except intraoral dental Services for treatment of a condition which is related to or developed as a result of cleft lip and/or cleft palate, unless otherwise included as a Covered Service of this Contract.
- d) Services for cosmetic reasons.
- e) Services for restoring tooth structure lost from wear, erosion, attrition, abrasion, or abfraction.
- f) Services related to protecting, altering, correcting, stabilizing, rebuilding or maintaining teeth due to improper alignment, occlusion or contour.
- g) Services related to periodontal stabilization of teeth.
- h) Habit appliances, night guards, occlusal guards, athletic mouth guards and gnathological (jaw function) Services, bite registration or analysis, or any related Services.

- i) Pre-medication, analgesia, hypnosis or any other patient management Services (except covered anesthetic Services).
- j) Charges for prescription drugs.
- k) Any Experimental or Investigational Procedures.
- l) Services that may otherwise have been covered, but due to the patient's underlying condition would not prove successful to improve the oral health of the patient.
- m) Any procedures done in anticipation of future need (except Covered Preventive Services).
- n) Hospital costs and any additional fees charged by the Dentist or hospital for hospital services or visits, or charges for use of any facility.
- o) Any anesthesia service not specifically included in Covered Services.
- p) Intraoral grafts when done in areas where a tooth/teeth are not present.
- q) Extraoral grafts (grafting of tissues or other substances from outside the mouth to or into oral tissues), augmentations or implants and/or any associated appliances. Removal of implants or any associated Services.
- r) Myofunctional therapy or speech therapy.
- s) Services for the treatment of any disturbances of the temporomandibular joint (TMJ), facial pain, or any related conditions, including any related diagnostic, preventive or interceptive Services.
- t) Services not performed in accordance with the laws of the State in which Services are rendered, Services performed by any person other than a person authorized by license to perform such Services, or Services performed to treat any condition, other than an oral or dental disease, malformation, abnormality or condition.
- u) Oral hygiene instructions or dietary instructions.
- v) Completion of forms, providing diagnostic information or records, or duplication of x-rays or other records.
- w) Replacement of lost, stolen or damaged appliances.
- x) Repair of appliances altered by someone other than a Dentist.
- y) Any Services including any associated Services or procedures not specifically included in Covered Services.
- z) Services for which charges would not have been made if this coverage had not existed, except for Services as provided under Medicaid.
- aa) Missed appointment charges.
- bb) Preventive control programs, including home care items.
- cc) Plaque control programs.
- dd) Services from a Dentist other than a Colorado PPO Participating Dentist (except for \$50.00 of emergency services provided outside of Colorado).
- ee) Self-inflicted injuries.
- ff) Bone grafting when done in the same site as a tooth extraction, implant, apicoectomy or hemisection.

### COORDINATION OF BENEFITS

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

**Plan:** Any Plan that provides benefits or Services for dental care expenses on a group or individual basis. This includes group and blanket insurance, self-insured and prepaid plans, automobile fault or no-fault insurance and government plans (except Medicaid).

**Primary Coverage:** Coverage that has the first responsibility for paying a claim. The Primary Coverage must pay up to its full liability.

**Secondary Coverage:** Coverage responsible for paying a claim after the Primary Coverage has paid up to its full liability.

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

- The Plan covering a Covered Person as an Employee will be primary over the policy or program covering a Covered Person as a Dependent.
- Dependent children's benefit payment determination will be as follows:
  - ❖ The Plan of the parent whose birthday (excluding year of birth) occurs earlier in a year will be primary, or;
  - ❖ If the parents are separated or divorced, the Plan of the parent who is ordered by court decree to take financial responsibility for dental expenses will be primary, or;
  - ❖ The Plan of the parent with custody is Primary and if the custodial parent has remarried, the step-parent's Plan is Secondary and the Plan of the parent without custody pays third.
- If the above rules do not establish an order of benefit payment, the Plan that has covered the Person for the longer period of time will be Primary except that the Plan covering the Person as a laid-off or retired employee or Dependent of such Person will be considered Secondary to any other Plan covering the Person.
- Any group Plan that does not contain a Coordination of Benefits provision is automatically primary.

If this Plan is Primary, this Plan will provide Benefits without regard to benefits provided by any other Plan. If this Plan is Secondary, this Plan will provide Benefits, which together with the other Plan will not exceed 100% of the allowable expense or this Plan's maximum benefit.

### SUBROGATION

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

### APPEAL PROCESS

A Covered Person has the right to appeal any adverse determination made on a claim, whether in whole or in part. An appeal request may be submitted in writing within 180 days of the date of the original Explanation of Benefits to:

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

A Covered Person may submit additional documentation in support of the appeal. A second-level or external appeal, in certain cases, may be available on qualified claims.

For those cases that qualify for an Independent External Review, a Covered Person may submit a request in writing within 60 days of the First or Second Level Appeal decision to the Appeals Analyst at the address above. The request must include a completed External Review Request Form that includes a signed consent authorizing Delta Dental to disclose protected health information pertinent to the external review.

## HIPAA

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

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

## COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

Covered Persons may be eligible to continue coverage under COBRA. The benefits will be the same as the benefits active Employees receive. The Covered Person will be responsible for the entire Premium amount, which cannot exceed 102% of the cost to the plan for a similarly situated active individual.

Qualifying events determine eligibility for COBRA coverage and the length of continuation. Eligible employees and dependents who lose coverage due to either the employee's termination of employment (other than gross misconduct) or a reduction in work hours to less than minimum may continue coverage for 18 months following the month in which the qualifying event occurs.

Eligible dependents who lose coverage due to any of the following Qualifying Events may elect to continue coverage for 36 months following the month in which the initial event occurs.

- An eligible employee's death;
- A divorce or legal separation from an eligible employee;
- A dependent child's ceasing to qualify as an eligible dependent under this Program; or
- An eligible employee's entitlement to Medicare benefits.

When the qualifying event is termination of the Employee's service, COBRA coverage may be extended for a Covered Person who qualifies for Social Security disability benefits. However,

the Covered Person's disability must have existed on the date of the qualifying event or began within the first 60 days of COBRA coverage. When a qualifying event occurs, the employer must give the Covered Person the necessary COBRA election form. This must be completed and returned to the employer within 60 days of the determination and before the end of the initial 18-month COBRA coverage period in order to extend COBRA coverage to 29 months.

COBRA Continuation coverage will be effective the first day of the month following termination of coverage. You must notify the plan administrator of your election of continuation of coverage within 60 days. Premium must be paid no later than 45 days after the election of continuation of coverage. Premium must be received by Delta Dental before any claims will be paid.

COBRA Continuation coverage will terminate on the earliest of the following:

- a) the last day of the month in which COBRA Continuation ends;
- b) the day the Contract terminates;
- c) the last day of the month that premium has been paid;
- d) the day the person becomes entitled to Medicare;
- e) the day the person becomes eligible for coverage under another group plan.

## GLOSSARY

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

**COMPLETED** means:

- For Root Canal Therapy: On the date the canals are permanently filled.
  - For Fixed Bridges (fixed partial dentures), Crowns, Inlays, Onlays, and other laboratory prepared restorations: On the date the restoration is cemented in place.
  - For Dentures and Partial Dentures (removable partial dentures): On the date that the final appliance is first inserted in the mouth.
  - For all other Services, on the date the procedure is Started.
- For benefit payment purposes, the date Completed will be considered as the date when a Covered Service is incurred.

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

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

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

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

**DEPENDENT** means

- the Employee's lawful spouse, including common law spouse or Same Gender Domestic Partner (SGDP);
- An Employee's son, daughter, stepson, stepdaughter or eligible foster child, including a legally adopted individual or an individual who is lawfully placed with the Employee for legal adoption, or a child for whom the Employee has

established parental responsibility (as evidenced by court documents), or a son or daughter of a Employee's SGDP, including a legally adopted individual or an individual who is lawfully placed with the Employee's SGDP for legal adoption, or a child for whom the Employee's SGDP has established parental responsibility (as evidenced by court documents), may be covered under the terms of this Benefits Booklet through the end of the calendar month in which the child turns 27

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

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

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

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

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

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

**STARTED** means:

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

## DENTAL TERMINOLOGY

**Amalgam:** A mixture of two or more metals in combination with mercury used as a restorative material.

**Anesthesia:** The Loss of sensation or feeling with or without loss of consciousness.

**Anterior:** Front. The first six teeth in the upper and lower jaw.

**Bitewing:** X-ray film; generally diagnostic to detect the presence of dental decay.

**Bridge:** (Fixed) An appliance replacing missing or extracted natural teeth, supported and held by attachments to restored (abutment) teeth and usually not removable.

**Cast:** Reproduction of the form of all or part of the dental arch (teeth and tissues) made from plaster or stone.

**Crown:** The portion of a human tooth covered by enamel. A dental prostheses restoring the function and esthetics of part or whole of the coronal portion of the natural tooth; usually composed of gold, porcelain, or acrylic resin.

**Denture:** An artificial substitute for missing natural teeth, either being complete (full) or partial.

**Denture Reline:** To resurface the tissue-borne areas of a denture with a new material.

**Endodontics:** A specialty area of dentistry concerned with diagnosis and treatment of diseases of the pulp chamber and canals.

**Extraction:** The separation and surgical removal of a tooth from its natural state.

**Flouride Treatment:** A topical application of a solution of a fluoride to the teeth to protect against decay.

**Impacted Tooth:** Condition in which the un-erupted or partially erupted tooth is positioned against another tooth, bone or soft tissue, thereby preventing complete eruption of the tooth.

**Implantation:** An insert into bone to support a crown or crowns, a partial denture or complete denture.

**Inlay:** A cast restoration prepared outside the mouth and cemented in a cavity preparation that is designed to restore two or three surfaces of the tooth. The remaining tooth margins are intact.

**Onlay:** A restoration that restores one or more cusps and adjoining occlusal surfaces or the entire occlusal surface and is retained by mechanical or adhesive means.

**Oral Hygiene Instruction:** Instruction on proper care of teeth.

**Palliative:** Action that relieves pain but is not curative.

**Panorex:** X-ray film that shows the curve of each dental arch and all the teeth therein; full mouth x-ray.

**Partial Denture:** An artificial device which replaces one or more but less than all of the natural teeth and associated structures that are supported by the teeth, being either removable or fixed.

**Periodontics:** The study and treatment of the gingival tissues; the tissues supporting the teeth.

**Prophylaxis:** A procedure of removing plaque, calculus and stains from tooth surfaces by scaling and polishing techniques; Cleaning.

**Rebase:** A process of refitting a denture by replacement of the denture base material.

**Reline:** To resurface the tissue side of a denture with new base material to make it fit more accurately.

**Resin:** Organic substances that may be solid or semi-solid in form. Resins are used as a filling material and are named according to their chemical composition, physical structure and means of activation or curing.

**Restoration:** The term applied to the end result of repairing and restoring or reforming the shape, form, and function of part or all of a tooth.

**Root Canal Therapy:** Treatment of a tooth having a damaged pulp, usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with insert sealing material.

**Sealants:** Protective covering applied to the occlusal surfaces of permanent bicuspid and molars to prevent decay in children's teeth.

**Space Maintainer:** A fixed or removable appliance designed to preserve the space created by the premature loss of a tooth.

**Temporomandibular Joint:** The connecting hinge mechanism between the mandible (lower jaw) and the base of the skull (temporal bone).

## NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Your Right to Obtain Additional Information or File a Complaint:**

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

### **Changes to this Notice**

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

### **Send Written Requests Regarding this Privacy Notice to:**

**Privacy Officer  
PO Box 5468  
Denver CO 80217-5468**

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

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

**Delta Dental of Colorado**

4582 South Ulster Street, Suite 800  
Denver, CO 80237-2567  
(303) 741-9300

**Customer Service:**

(303) 741-9305 or (800) 610-0201