



**Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 2517
City of Albuquerque**

Benefit Period: July 1 through June 30

Covered Services:

	PPO Dentist	Premier Dentist	Non-participating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	80%	80%
Emergency Palliative Treatment – to temporarily relieve pain	100%	80%	80%
Sealants – to prevent decay of permanent teeth	100%	80%	80%
Brush Biopsy – to detect oral cancer	100%	80%	80%
Radiographs – X-rays	100%	80%	80%
Periodontal Maintenance – cleanings following periodontal therapy	100%	80%	80%
Basic Services			
Minor Restorative Services – fillings	85%	85%	85%
Endodontic Services – root canals	85%	85%	85%
Periodontic Services – to treat gum disease	85%	85%	85%
Oral Surgery Services – extractions and dental surgery	85%	85%	85%
Other Basic Services – misc. services	85%	85%	85%
Major Services			
Crown Repair – to individual crowns	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Relines and Repairs – to bridges, dentures, and implants	50%	50%	50%
Prosthetic Services – bridges, implants, and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	No Age Limit	No Age Limit	No Age Limit

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Routine prophylaxes (cleanings) and periodontal maintenance are payable twice per calendar year.
- Fluoride treatments are payable twice per calendar year for people up to age 19.
- Space maintainers are payable once per area per lifetime for people up to age 14.
- Bitewing X-rays are payable twice per calendar year and full-mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Diagnostic casts are Covered Services.
- Sealants are payable once per tooth per three-year period for the occlusal surface of permanent molars up to age 17. The surface must be free from decay and restorations.

- Composite resin (white) restorations are Covered Services on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.
- Prescription medicaments are Covered Services for dentally related conditions.

Maximum Benefit Amount: \$1,500 per person total per benefit year on all services except diagnostic and preventive, X-rays, sealants, full mouth debridement, periodontal maintenance, emergency palliative, consultations, cephalometric films, photos, and orthodontics (including fiberotomy, surgical repositioning, and devices to facilitate tooth eruption). \$1,200 per person total per lifetime on cephalometric films, photos and orthodontics (including fiberotomy, surgical repositioning, and devices to facilitate tooth eruption).

Deductible: \$50 deductible per person total per lifetime limited to a maximum deductible of \$150 per family per lifetime. The deductible does not apply to diagnostic, preventive, X-rays, sealants, full mouth debridement, periodontal maintenance, emergency palliative, consultations, cephalometric films, photos, and orthodontics (including fiberotomy, surgical repositioning, and devices to facilitate tooth eruption).

Eligibility Provisions: An employee who works the minimum number of hours per week and/or satisfies the eligibility definition(s) and Eligibility Waiting Period as specified by the Client and agreed to by Delta Dental.

Also eligible if you are enrolled are your legal spouse, and your children, as defined in the Dental Benefit Handbook. Eligible children include children through the end day prior to the day on which the child turns age 26 regardless of employment, marital, student or dependent status, and unmarried children over age 26 who cannot support themselves because of a mental or physical impairment which meets the additional requirements for eligibility. Eligibility is subject to timely enrollment or any other applicable requirements.

Subject to any additional requirements which may apply, individuals are eligible to enroll on the first day of the payroll period following submittal of completed enrollment card when submission is within 31 days of date of hire.

Subject to any other provisions which may also apply, benefits will cease on the last day of the month in which the employee is terminated.

Special Benefit Provisions: None.

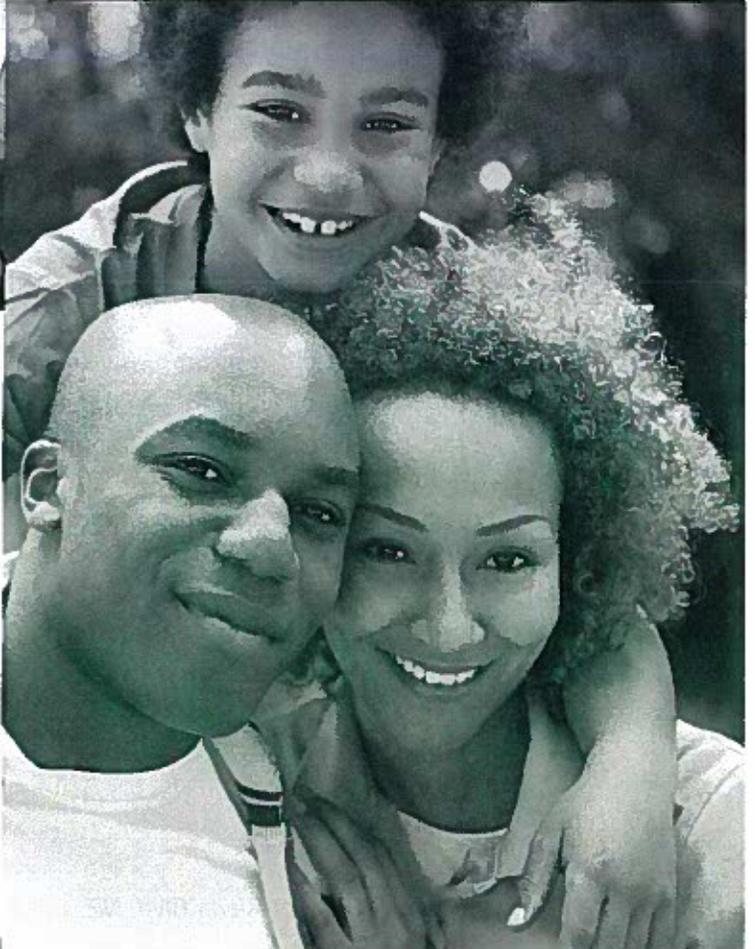
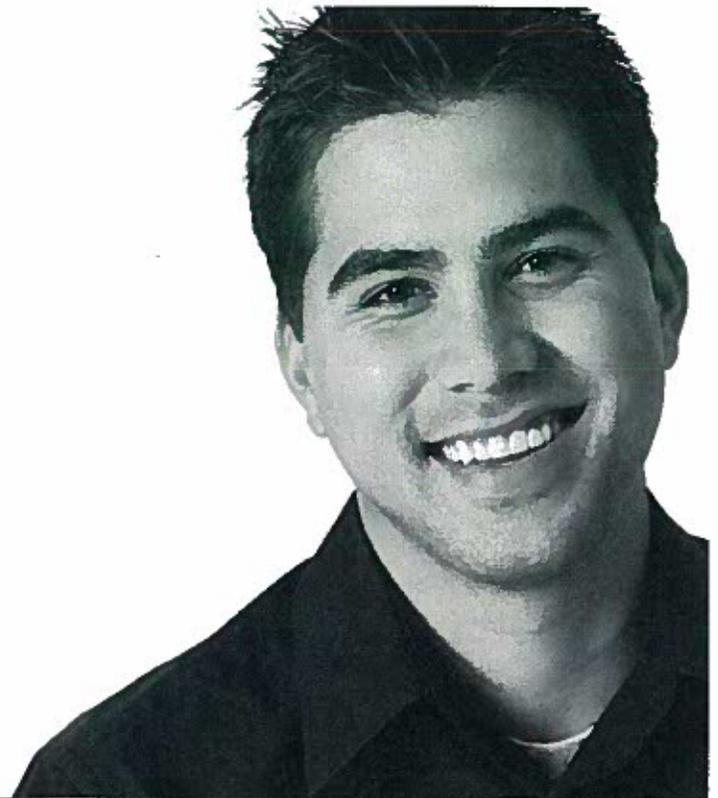
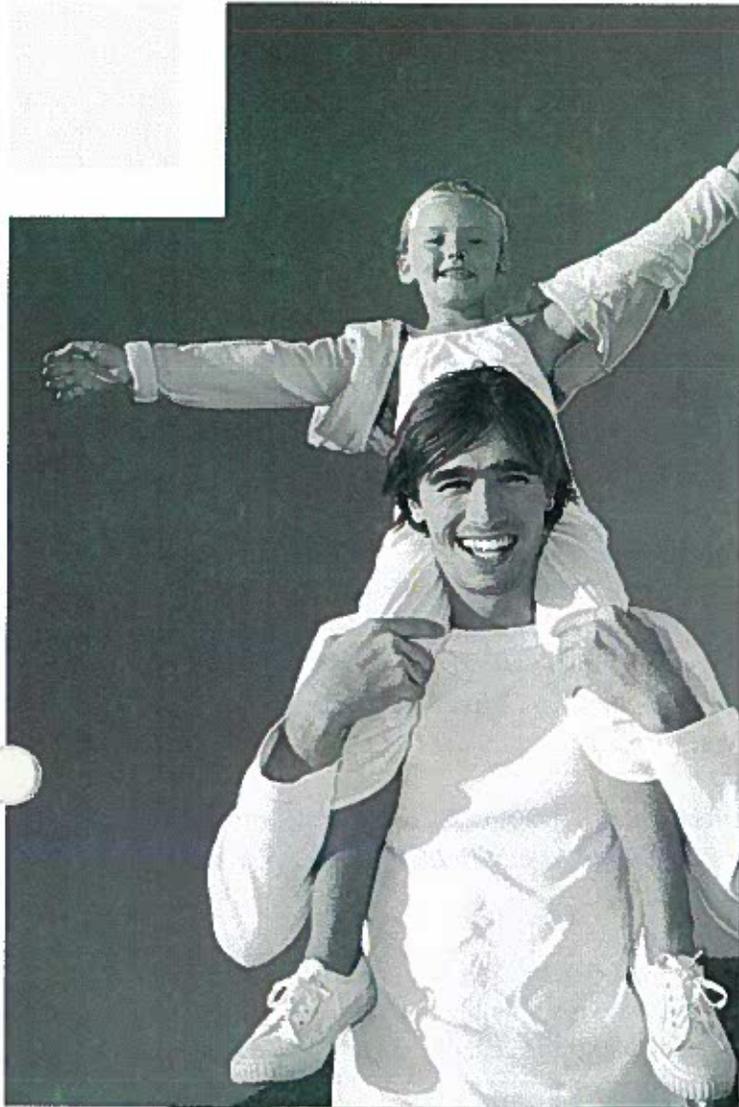
UNDERSTAND YOUR BENEFITS: This Summary of Benefits is intended only to highlight benefit levels. It does not reflect all limitations or plan provisions and does not provide complete coverage information. Refer to your Dental Benefit Handbook for other important eligibility and plan provisions and/or call Delta Dental's Benefit Services Department to speak with a representative who can answer your coverage questions.

Ask your dentist for a Pre-determination of benefits anytime more costly procedures are anticipated. When requested by a dental provider, an advance estimate of benefits payable can be provided by Delta Dental before dental care services are received. Pre-determination is strongly recommended and there is no charge for this service.

This Summary of Benefits is attached to the Dental Benefit Handbook and made part of it. This Summary of Benefits supersedes any contract provision of the Dental Benefit Handbook and the Group Administrative Services Contract.



Dental Benefit Handbook





To: Delta Dental Subscribers
From: Delta Dental of New Mexico Benefit Services
Re: Amendment to your Dental Benefit Handbook

A law in New Mexico (one of 20+ states which now have similar legislation) which was passed on April 7, 2011 prevents any dental insurance company or dental plan administrator (such as Delta Dental) from holding a dentist to fee maximums for services which are not covered under the dental plan in which a patient is enrolled. Prior to the law, Delta Dental dentists were required under their contracts with Delta Dental to honor fee maximums regardless of whether the dental plan covered the treatment being provided.

As a result of this law (SB260), an amendment to your Dental Benefit Handbook has been made. This amendment has no impact on the benefits for any services covered under your dental plan. It also does not have any impact when a member is paying for services because he/she exceeded the annual plan maximum or because of a limitation in the plan (such as a frequency or age limit) which applies to what would otherwise have been a covered service.

The change to your Dental Benefit Handbook was effective April 7, 2011. As of that date, the following statements from section *II A 1., How The Plan Works / Delta Dental Provider Networks Information*, were not applicable (removed):

Delta Dental dentists agree to fee maximums for both covered and non-covered services. This can be an important benefit because members are responsible for full payment of non-covered services. If non-covered services are needed, and the cost of that care is reduced, members save money.

All the terms, benefits, exclusions and provisions of your employer's contract with Delta Dental which are not specifically amended as shown above remain in full force and in effect.

As always, questions specific to a specific claim or Explanation of Benefits can be answered by one of our Delta Dental Benefit Service Representatives by calling (505) 855-7111 or, if calling from outside Albuquerque, (877) 395-9420.

Oral health is an important part of overall health. We thank you for your enrollment and appreciate the opportunity you give us to be of service.



Welcome to the growing number of people who receive fully insured dental benefits from Delta Dental of New Mexico.

Benefits are provided under a Group Dental Insurance Contract ("Contract") entered into between an employer ("Group") and Delta Dental Plan of New Mexico, Inc., ("Delta Dental"). Claims for benefits are sent to Delta Dental. Benefit determination, administration and claims payment is the responsibility of Delta Dental. In addition to providing benefits, Delta Dental administers enrollment, customer service and the Delta Dental provider network(s) selected by the Group.

This Dental Benefit Handbook, along with the Summary of Benefits, describes important plan provisions. Any additional provision or exception shown on the Summary of Benefits supersedes any contract provision in this handbook or in the Group Dental Insurance Contract.

Enrolled persons will be notified in writing by Delta Dental of any material changes to the group dental plan. Any modification of the plan will apply to all persons covered by the plan at the time of such changes, whether or not employed.

The described benefits are extended to enrolled persons as long as the premium is paid to Delta Dental and all other provisions of the Contract are satisfied. This handbook is provided automatically, at no charge, upon enrollment in this plan and then upon request. Please take time now to become familiar with the dental coverage. For answers to questions about the benefits, please call:

Delta Dental's Benefit Service Department
(505) 855-7111
or
toll free (877) 395-9420

Good oral health is an important part of good general health. Delta Dental plans are designed to promote regular dental visits. Take advantage of your benefits by calling a Delta Dental dentist today for an appointment.

For a current listing of Delta Dental dentists in New Mexico, visit the website at: deltadentalnm.com

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I. ELIGIBILITY AND ENROLLMENT

A. Who Is Eligible?

1. Individuals who meet one of the following qualifications and enroll in the plan are eligible.
 - An employee who works the minimum number of hours per week and/or satisfies the eligibility definition(s) and Eligibility Waiting Period as specified by the Group and agreed to by Delta Dental.
 - A dependent of the eligible employee defined as:
 - husband or wife (spouse) as defined by New Mexico State Law;
 - unmarried children from birth through the end of the month of their 25th birthday who are primarily dependent on the enrolled employee for support;
 - unmarried children age 25 or older who cannot support themselves because of mental or physical impairment that began before age 25 and are dependent on the enrolled employee for support and maintenance. Proof of these facts must be given to Delta Dental within 31 days if requested.
2. The definition of “children” for the purposes of coverage under this dental plan is:
 - natural child(ren);
 - newly-born child(ren);
 - stepchild(ren);
 - child(ren) of a non-custodial spouse of any enrolled employee
 - child(ren) for whom the enrolled employee is the legal guardian;
 - legally adopted child(ren), including children placed with an enrolled employee or spouse for adoption. Coverage shall apply without any pre-existing benefit restrictions;
 - foster child(ren) living in the same household as an eligible employee or spouse as a result of placement by a state licensed placement agency;
 - dependent child(ren) required by a Qualified Medical Child Support Order (QMCSO) or a court or administrative order are also eligible for coverage without regard to any Open Enrollment restrictions.
3. The following persons are **NOT** eligible: spouses or children in military service and any individuals not defined as eligible above.

B. Enrollment Requirements

1. Employees and their eligible dependents **must enroll** to be covered under the plan. Unless required by law, eligible dependents **may enroll only** if the eligible employee enrolls. Enrollments must be completed and received within 31 days of the eligibility date.

2. Newly eligible employees and dependents may enroll in accordance with their dates of eligibility.
3. An enrolled employee may elect to enroll eligible dependents under the following conditions:
 - eligible dependents must be enrolled at the time the eligible employee becomes enrolled, or within 31 days from the date they become dependents, or within 31 days of loss of other dental coverage, or during an Open Enrollment period;
 - enrolled employees may not enroll as dependents;
 - dependents may not be enrolled unless the eligible employee enrolls;
 - married eligible employees of the same group may enroll separately or together, but not both;
 - dependents may enroll as the dependent of only one enrolled employee;
 - newly-born dependents become eligible on the date of birth and may be enrolled on the Group's effective date, within 31 days of birth or at Open Enrollment.
4. Delta Dental will allow an annual Open Enrollment period for all eligible employees of the Group. Open Enrollment is a period of time specified by the Group and approved by Delta Dental to allow eligible employees and/or their dependents to enroll in the plan or to cancel coverage under the plan for the renewed contract period. Open enrollment changes are effective the first day of the Group's renewed contract period.
5. If an eligible employee does not elect coverage when first eligible, he/she may only enroll during the next Open Enrollment period. If an eligible employee elects not to enroll himself/herself or dependents, a waiver must be signed on the enrollment form at the time of initial eligibility. For individuals waiving due to other dental coverage, this waiver does not affect eligibility for enrollment within 31 days if a loss of coverage occurs in the future. Proof of loss of other dental coverage must be provided to Delta Dental, if requested.
6. Delta Dental will not pay benefits for persons who are not enrolled, nor will Delta Dental pay benefits for an enrolled person if the Group premium has not been paid for that person for the month in which dental services are performed.
7. The Group is responsible for submitting monthly premium to Delta Dental on behalf of all enrollees. Premium may include contributions by enrollees as determined by the Group.

C. Effective Dates of Coverage

1. Unless otherwise approved by Delta Dental and indicated on the Summary of Benefits, coverage for an enrolled employee becomes effective on the first day of the month following that employee's date of eligibility.
2. Coverage for newly-born child(ren) will become effective on the date of birth, if enrolled within 31 days, but not before the coverage date applicable to the enrolled employee.
3. Coverage for enrolled dependents, except as noted in paragraph two (2) above, becomes effective on the same date as the enrolled employee or on the first of the month following the dependent's date of eligibility.

4. Delta Dental must receive notification of any change of eligibility status within 31 days of a change in eligibility status or a qualifying event. The corresponding change in coverage will become effective on the first day of the following calendar month.

D. Re-enrollment After Voluntary Cancellation of Coverage

1. An enrolled employee may cancel employee or dependent coverage during an annual Open Enrollment period. Re-enrollment is not available until the next annual Open Enrollment period.
2. An enrolled employee who cancels coverage or cancels dependent coverage at any time other than an Open Enrollment period may not re-enroll those same dependents unless there is a subsequent Qualifying Event or proof that the dependents remained continuously covered under another group dental plan. The eligible employee may, however, elect "employee-only" coverage at a future Open Enrollment period.
3. Re-enrollment in this plan between Open Enrollment periods after voluntary cancellation of coverage is not allowed for any reason other than the loss of other dental coverage. Re-enrollment must occur within 31 days of loss of other dental coverage and proof of loss must be provided to Delta Dental, if requested.

II. HOW THE PLAN WORKS

A. Delta Dental Provider Networks Information

1. The provider network which is considered "In-Network" is indicated on the Summary of Benefits. Out-of-pocket costs can be much higher if services are received from non-participating dentists, so it is important to receive services from In-Network dentists whenever possible.
 - Delta Dental dentists will not bill a Delta Dental patient for any amount over the Delta Dental Maximum Approved Fee applicable to the service provided and the provider agreement with Delta Dental. Members are protected from unexpected "balance bill" charges.
 - Participating dentists have agreed to bill Delta Dental, avoiding the need for Delta Dental members to pay first and wait for reimbursement. For covered services, subscribers are initially responsible only for co-payments and deductibles, if any.
 - Delta Dental dentists agree to fee maximums for both covered and non-covered services. This can be an important benefit because members are responsible for full payment of non-covered services. If non-covered services are needed, and the cost of that care is reduced, members save money.
 - Members have direct access to Delta Dental dentists. Availability and appointment scheduling is always independently determined by each individual dentist, not by Delta Dental.
 - Pre-selection of a dentist is never required. Each member of the family may use a different dentist.

2. A patient's share of the cost for any covered service depends on whether the dentist participates in the provider network(s) indicated on the group's Summary of Benefits. Delta Dental has more than one provider network available to employer groups.

- Delta Dental Premier® is a national provider network, with dentists in every state. This network is designed to provide the broadest selection of dentists and approximately three out of every four dentists in the country participate.
- Delta Dental PPOSM is a second, smaller national network which is structured to provide additional cost savings.
- Advantage is a provider network which is offered exclusively in New Mexico.

Some group plans are designed to feature a single Delta Dental provider network. Other group plans feature Delta Dental Premier® in addition to another network. In these plans, which are called Point of Service plans, services received from any dentist in either network are considered In-Network.

B. How Benefit Payment is Based on the Dentist Selected

1. If a dentist participates in the provider network indicated on the Summary of Benefits, all services received from that dentist are considered In-Network.
2. If a dentist participates in Delta Dental Premier, but not in the network indicated on the Summary of Benefits:
 - Services received from that dentist are considered out-of-network;
 - These dentists are allowed to balance bill patients up to Delta Dental Premier Maximum Approved Fees. However, because the amount of balance billing is limited, and because the fee allowables are higher than those applicable to non-participating dentists, the additional out-of-pocket costs will be lower than when services are received from an out-of-network dentist who does not participate in Delta Dental Premier.
3. Non-participating dentists are dentists who do not participate in *any* Delta Dental dentist network. Benefits apply for covered services received from a non-participating dentist, however:
 - These dentists are not subject to agreements which would require them to honor Delta Dental pricing maximums for both covered and non-covered services;
 - Non-participating dentists may bill their patients up to the full amount of their submitted charges. Benefit payments for covered services received from a non-participating dentist are subject to Delta Dental fee maximums and these may be greatly reduced for non-participating providers;
 - Non-participating dentists are not subject to other member protections, such as guarantees on restorative services, which are required of dentists who participate with Delta Dental;
 - Payments made by Delta Dental for services received from a non-participating provider may be paid to the provider or directly to the enrolled subscriber, depending on the state in which the services were received and whether there was a valid Assignment of Benefits. Subscribers may be responsible for payment at the time services are received for the full amount due if required by

the non-participating provider.

Maximize benefits by selecting, whenever possible, an In-Network Delta Dental dentist. For online access to New Mexico provider directories, or to search for a dentist nationally, visit the website at deltadentalnm.com and click in the **Searching for a Dentist** box. Be sure to select the provider network shown on the Summary of Benefits.

For assistance, subscribers may also call Delta Dental Benefit Services at (505) 855-7111 or toll free at (877) 395-9420.

C. Accessing Benefits

To use the plan, follow these steps:

1. Read this handbook and the Summary of Benefits carefully to become familiar with the benefits, Delta Dental's method of payment and the provisions of the plan.
2. Whenever possible, select a participating provider. Make a dental appointment and tell the dental office that dental coverage is under this plan. If the office is not familiar with the coverage applicable to this plan or has any questions regarding the plan, the dental office may contact the Delta Dental Benefit Service Department at (505) 855-7111 or toll free (877) 395-9420.
3. Following dental treatment, a claim needs to be filed with Delta Dental. All participating Delta Dental dentist offices will file the claim directly with Delta Dental. Non-participating dentists may require patients to file their own claims. Claims for benefits must be submitted to Delta Dental in writing within 12 months from the date services were provided. Failure to submit a claim within the time limitation shall not void or reduce the claim if it is shown it was not reasonably possible to submit within the 12 months, and that the claim was submitted as soon as reasonably possible. If Delta Dental does not respond within 15 days to a request to furnish a dental claim form, the requirements for claims submission shall be deemed to have been met upon the submission to Delta Dental.
4. Enrolled individuals are responsible for filing claims for services received from a non-participating dentist outside of the United States. A claim form, including the "Patient Section," must be completed. Prior to submission to Delta Dental, the dental office providing services must complete an itemization of services that includes tooth number, if applicable, a description of each individual service, a date of service, a fee for each individual service and a signature by the dentist.

If the services performed outside of the United States are for extractions, crowns, bridges, dentures, or partial dentures, an x-ray of the area must be obtained prior to the service being considered for benefits. Enrolled persons are responsible for obtaining the necessary documentation for services provided, for filing a claim with Delta Dental, and for payment to the dentist at the time services are performed.

Delta Dental will calculate foreign currency benefit payments based on published currency conversion tables that correspond to the date of service.

5. Completed claim forms should be submitted to Delta Dental, 2500 Louisiana Boulevard N.E. Suite 600, Albuquerque, New Mexico 87110. The Delta Dental Benefit Service Department is available Monday through Friday, 8:00 am – 4:30 pm (Mountain Time) at (505) 855-7111 or toll free (877) 395-9420.

6. Within 30 days of receiving a valid claim, Delta Dental will send an Explanation of Benefits which records Delta Dental's benefit determination, any payment made by Delta Dental and any amount still owed to the dental provider. The Explanation of Benefits will be mailed to the enrolled employee, or other appropriate beneficiary, and to the treating dentist if a Delta Dental participating dentist. The 30-day period for claim determination may be extended an additional 15 days if matters beyond the control of Delta Dental delay benefit determination. Notification of any necessary extension will be sent prior to the expiration of the initial 30-day period.
7. If a claim for benefits is reduced or denied, the Explanation of Benefits will state the reason for the adverse determination. Should an enrolled person believe Delta Dental incorrectly denied all or part of a claim, a review may be requested by following the steps described in Section V, "Claims Appeal."

D. Out-of-Pocket Expenses

To help keep premium levels affordable, the plan is designed for cost sharing between the enrolled person and Delta Dental for the services provided by a dental provider.

1. Deductible

The plan may require enrolled persons to pay a portion of the initial expense toward some covered services in each benefit period. When applicable, the amount of this deductible is stated in the Summary of Benefits.

2. Patient Copayment

The patient copayment is the percentage of covered services for which the enrolled person is responsible for payment to the dental provider. The amount of patient copayment will vary depending on the level of benefits for the particular dental treatment and the selection of a participating or a non-participating provider as described in the accompanying Summary of Benefits.

3. Maximum Benefit Amount

Delta Dental will pay for covered services up to a maximum amount for each enrolled person for each benefit period. Enrolled persons are responsible for payment of amounts due for any dental services that exceed the maximum benefit applicable in the benefit period. The maximum benefit amount is stated in the Summary of Benefits.

E. Predetermination of Benefits

A predetermination of benefits is not required as a condition for payment of benefits. However, if extensive dental work is needed, Delta Dental recommends that a predetermination of benefits be obtained prior to the services being performed. A predetermination of benefits provides both the patient and the dentist with an estimate of the benefit levels, maximums, and limitations that may apply to a proposed treatment plan. Most importantly, the enrolled person's share of the cost will be estimated.

Dental offices are very familiar with the predetermination of benefits procedures and will gladly provide this service to their patients.

A predetermination is not a guarantee of payment. Payment of benefits is subject to plan provisions and eligibility at the time the service is actually provided.

F. Clinical Review

1. All claims are subject to review by a licensed dental consultant.
2. Payment of benefits may require that an enrolled person be examined by a licensed dental consultant or an independent licensed dentist.
3. Delta Dental may require additional information prior to approving a claim. All information and records acquired by Delta Dental will be kept confidential.

G. To Whom Benefits are Paid

1. Delta Dental will pay a participating provider directly for covered services rendered. The enrolled person is responsible for paying the provider directly for any non-covered services.
2. Delta Dental will pay a New Mexico non-participating provider when a valid assignment of benefits is received on the individual claim.
3. Delta Dental will pay a non-participating provider practicing outside the state of New Mexico when required by the Delta Dental member company in that state, when a valid assignment of benefits is received on the individual claim.
4. All available benefits not paid to the dental provider shall be payable to the enrolled person or to the estate of the enrolled person.
5. Delta Dental must pay directly to the Human Services Department or Indian Health Services any eligible dental benefits under this Contract which have already been paid or are being paid by the Human Services Department or Indian Health Services on behalf of the enrolled person under the State's Medicaid Program or Indian Health Program.
6. In cases of a Qualified Medical Child Support Order (QMCSO), Delta Dental will send benefit payments directly to participating providers. Payment of benefits for services obtained from non-participating providers will be directed in compliance with the valid order of judgment provided in the QMCSO.

H. Right to Recover Benefits Paid By Mistake

If Delta Dental makes a benefit payment to the enrolled person or to a provider and the patient is subsequently determined as not eligible for all or part of that benefit, Delta Dental has the right to recover payment. The right to recover a payment includes the right to deduct the amount paid from future dental benefits for any covered family member.

III. BENEFITS, LIMITATIONS AND EXCLUSIONS

Unless otherwise specified on the Summary of Benefits, the benefits, limitations and exclusions described in this section apply to this plan. A dental service will be considered for benefits based on the date the service is started. Benefits are subject to processing policies of Delta Dental and the terms and conditions of the entire Contract. Refer to the accompanying Summary of Benefits for patient copayment amounts. In addition to the limitations applicable to each type of service, refer to "General Limitations and Exclusions" for a detailed list of other applicable plan exclusions.

A. Diagnostic and Preventive Services

Diagnostic: procedures to aid the dentist in choosing required dental treatment (oral examinations, diagnostic consultations, clinical oral evaluations and x-rays).

Palliative: minor treatment to relieve emergency pain when supporting narrative is submitted by the provider.

Preventive: cleanings, application of fluoride, space maintainers and sealants. Periodontal maintenance is considered to be a cleaning for benefit determination or payment purposes.

Limitations on Diagnostic and Preventive Services

1. Benefits for oral examinations, including diagnostic consultations, emergency or re-evaluation exams and clinical oral evaluations and are limited as shown in the Summary of Benefits.
2. Dependents under the age of fourteen (14) are limited to routine child cleanings. Dependents age fourteen (14) and over will be considered adults for the purpose of determining benefits for cleanings.
3. A separate fee for periodontal maintenance is disallowed within three (3) months of other periodontal therapy provided by the same dentist.
4. Full mouth debridement is only a benefit when necessary to enable comprehensive evaluation and diagnosis and is limited to once per lifetime.
5. X-rays exceeding the diagnostic equivalent of a complete series, will be disallowed when taken on the same date of service.
6. Bitewing x-rays exceeding the diagnostic equivalent of a complete set of bitewings, will be disallowed when taken on the same date of service.
7. Emergency palliative treatment does not include services and supplies that exceed the minor treatment of pain.
8. Services for diagnostic casts, photographs, laboratory and diagnostic tests, non-routine diagnostic imaging, non-surgical collection of specimens, oral hygiene instruction, home fluoride, mounted case analysis, and nutrition or tobacco counseling are not covered.
9. A separate fee for pulp vitality tests is a benefit only in conjunction with an emergency exam or palliative treatment on the same date of service.
10. Benefits for Sealants are limited to permanent molars free from occlusal restorations.
11. A separate fee for the replacement of a sealant by the same provider is not allowed within three (3) years of the initial placement.
12. Benefits for space maintainers are limited to once per lifetime per site.
13. A separate fee for the recementation or repair to a space maintainer by the same provider is not allowed within six (6) months of the original treatment. Six (6) months after the original treatment date, recementation or repair is a benefit once per twelve (12) month period.
14. A separate fee for the removal of a space maintainer by the same provider who placed the initial appliance is not allowed.

15. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

B. Restorative Services

Restorative services are amalgam, resin-based composite restorations (fillings), stainless steel and prefabricated stainless steel restorations. These covered services are a benefit for the treatment of visible destruction of the hard tooth structure resulting from the process of decay or injury.

Limitations on Restorative Services

1. A separate fee for the replacement of a restoration or any component of a restoration on a tooth for the same surface by the same provider is not allowed if done within twenty-four (24) months of the initial service.
2. When multiple restorations involving multiple surfaces of the same tooth are performed, benefits will be limited to that of a multi-surface restoration. A separate benefit may be allowed for a non-contiguous restoration on the buccal or lingual surface(s) of the same tooth subject to clinical review.
3. Resin restorations in posterior teeth are limited to bicuspid and maxillary first molars. On all other teeth, they are considered optional services and are limited to the equivalent amalgam restoration benefit.
4. Prefabricated resin crowns are a benefit for primary anterior teeth only.
5. Preventive restorations are not a covered benefit.
6. Services for metallic, porcelain/ceramic, or composite/resin inlays are limited to the benefit for the equivalent amalgam/resin procedure.
7. Services for metallic, porcelain/ceramic or composite/resin onlays are subject to clinical review and limitations on optional services may apply.
8. Replacement of existing restorations for any purposes other than restoring active tooth decay or fracture is not covered.
9. Separate fees for more than one pin per tooth or a pin performed on the same date of service as a build-up are not allowed. Pin retention, when dentally necessary, is allowed once per tooth in a twenty-four (24) month period.
10. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

C. Basic Services

Anesthesia: intravenous sedation and general anesthesia.

Endodontics: treatment of dental pulp disease and surgical procedures involving the root.

Extractions: surgical and non-surgical extractions.

Oral Surgery: oral surgery including oral maxillofacial surgical procedures of all hard and soft tissue of the oral cavity.

Periodontics: treatment of diseased gums and bones supporting teeth. For purposes of benefit calculation, a quadrant is defined as four (4) teeth.

Limitations on Basic Services

1. Intravenous (IV) sedation and general anesthesia are not benefits for non-surgical extractions and/or patient apprehension.
2. Intravenous (IV) sedation and general anesthesia are benefits only when administered by a licensed dentist in conjunction with specified surgical procedures, subject to clinical review and when medically necessary.
3. Nitrous oxide and non-intravenous conscious sedation are not covered benefits.
4. Pulpal therapy procedure benefits are limited to once in a 24 month period.
5. A separate fee is not allowed for pulp therapy procedures when performed on the same day, by the same provider, as other surgical procedures involving the root.
6. A separate fee is not allowed for a pulp cap placed on the same day as a restoration or within twenty-four (24) months of a pulp cap placed on the same tooth by the same provider.
7. A pulpotomy or pulpal debridement is a benefit once per tooth per lifetime.
8. Pulpotomies and pulpal therapy procedures are limited to primary teeth.
9. Benefits for certain oral surgery procedures are subject to the receipt of an operative report and clinical review, and may be reduced by benefits provided under the patient's medical benefits coverage, if applicable.
10. Root canal therapy in conjunction with overdentures is not a benefit.
11. Re-treatment of root canal therapy or re-treatment of surgical procedures involving the root, by the same provider, within twenty-four (24) months, is considered part of the original procedure and a separate fee is not allowed.
12. Apexification benefits are limited to permanent teeth, once per tooth per lifetime. This procedure is disallowed if performed by the same dentist within 24 months of root canal therapy.
13. Endodontic endosseous implants are not a benefit.
14. Tooth transplantation, including re-implantation, is not a benefit.
15. Periodontal scaling and root planing benefits are limited to once per quadrant or site in a two (2) year period.
16. Periodontal surgeries, such as gingivectomy, gingival flap, osseous surgery, bone grafts and tissue graft procedures are limited to once per site in a three (3) year period. A gingivectomy performed on the same date of service as a restoration is an eligible expense.
17. Separate fees for crown lengthening in the same site are disallowed when charged by the same dentist within three (3) years.
18. Additional fees for more than two (2) quadrants of osseous surgery on the same day of service are disallowed.

19. Separate fees for postoperative visits and dressing changes by the same dentist performing the surgery are disallowed.
20. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

D. Major Services

Crown Build-Ups and Substructures: benefits when necessary to retain a cast restoration due to extensive loss of tooth structure from caries, fracture or endodontic treatment.

Crowns, Cast Restorations and Veneers, Including Repairs to Covered Procedures: benefits when a tooth is damaged by decay or fractured to the point that it cannot be restored by an amalgam or resin filling. Benefits will not be affected by prior placement of amalgam or composite restorations.

Implants: specified services, including repairs, and related prosthodontics.

Prosthodontics: procedures for construction, modification, or repair of bridges, partial or complete dentures.

Limitations on Major Services:

1. Replacement of any crowns, cast restorations, build-ups, implants, substructures or veneers is not a benefit within five (5) years of previous placement.
2. Replacement of any bridge or denture is not a benefit if the previous placement is less than five (5) years old.
3. Services which are beyond the standard of care customarily provided, or not necessary to restore function are limited to the benefit applicable to a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
4. Overdentures are not a covered service.
5. A separate fee for a crown build-up or substructure is disallowed when enough tooth structure is present to retain a cast restoration.
6. Posts and cores in addition to a crown are a benefit only on endodontically treated teeth. In addition to the requirement for endodontic treatment, anterior teeth must have insufficient tooth structure to support a cast restoration. Fees are disallowed when these requirements are not satisfied.
7. A separate fee for the recementation or repair to crowns, implants, onlays, post and core or bridges within six (6) months of the original treatment by the same provider is disallowed. After six (6) months, these services are a benefit once per twelve (12) months. Procedures to modify existing partials and dentures are considered construction of prosthesis versus the repair of a prosthesis.
8. Surgical placement of eposteal or transosteal implants is not a benefit.
9. Surgical placement of an endosteal implant is a benefit once per tooth per five (5) year period.
10. Implant retained or supported crowns and retainers with metallic alloy content less than high noble are not benefits.

11. Implant maintenance procedures are limited to twice in a benefit period.
12. The replacement of a semi-precision or precision attachment of an implant/abutment supported prosthesis is considered an optional service and is not a benefit.
13. A separate fee for the removal of an implant within twenty-four (24) months of the original placement, by the same provider, is disallowed. After twenty-four (24) months, this service is a benefit once per tooth per lifetime.
14. A separate fee is not allowed for a radiologic surgical implant index.
15. A posterior fixed bridge and a partial denture are not benefits in the same arch. Benefit is limited to the allowance for a partial denture.
16. Temporary restorations, temporary implants and temporary prosthodontics are considered part of the final restoration. A separate fee by the same provider is not allowed.
17. Benefits for porcelain crowns or porcelain supported prosthetics on posterior teeth are limited to bicuspid and maxillary first molars. On all other teeth, they are considered optional services and benefits are limited to the equivalent metal crown or metal supported prosthetic benefit.
18. Initial prosthetic placement for congenitally missing teeth is not covered.
19. Maxillofacial prosthetics are not a benefit.
20. Crowns, implants, prosthodontics and all related services are not benefits for dependents under the age of sixteen (16).
21. Fees for full or partial dentures include any reline/rebase, adjustment or repair required within six (6) months of delivery except in the case of immediate dentures. After six (6) months, adjustments to dentures are a benefit twice in a twelve (12) month period and relines or rebases are a benefit once in a three (3) year period.
22. Tissue conditioning is not a benefit more than twice per denture unit in a three (3) year period.
23. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

E. Orthodontic Services

No payment will be made by Delta Dental for Orthodontic Services unless stated in the Summary of Benefits.

Orthodontic Services means procedures performed by a dentist using appliances to treat poor alignment of teeth and their surrounding structure. The benefit determination for the Orthodontic Services Lifetime Maximums may include specific Non-Orthodontic procedure codes that are directly related, as determined by Delta Dental, to be part of an Orthodontic treatment plan. Procedures directly related to Orthodontic Services will only be considered eligible expenses if benefits for Orthodontic Services apply.

Payment for charges that exceed the maximum benefit applicable to Orthodontic Services is the patient's responsibility. Refer to the Summary of Benefits to verify if the plan includes coverage for Orthodontic Services along with specific and lifetime benefit provisions.

Limitations on Orthodontic Services

1. If the enrolled person is already in orthodontic treatment, benefits shall commence with the first treatment rendered following the patient's effective date or any applicable benefit waiting period. Charges for treatment incurred prior to the patient's effective date are not covered.
2. Benefits will end immediately if orthodontic treatment is stopped.
3. Charges to repair or replace any orthodontic appliance are not covered, even when the appliance was a covered benefit under this or any other plan.
4. Charges for x-rays (except for cephalometric film) and extractions are not covered under Orthodontic Services.
5. Oral facial images and diagnostic casts are a benefit once per orthodontic treatment program. Additional fees for these procedures are disallowed when performed by the same dentist.
6. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

F. General Limitations and Exclusions

1. A Missing Tooth Exclusion applies to the plan if stated in the Summary of Benefits. This means the replacement of any tooth missing prior to the effective date of an enrolled person's coverage under this Contract is not covered. This exclusion will not apply to an adopted child with a tooth missing prior to the date of formal placement and adoption.
2. A waiting period prior to obtaining some services applies if stated on the Summary of Benefits. This means an enrolled person is not eligible for benefits for those services until he/she has been continually enrolled under this Contract for the time frame stated in the Summary of Benefits.
3. Services for any covered procedures which exceed the frequency or age limitation shown on the Summary of Benefits are not eligible for benefits. Unless stated otherwise, all frequency limitations are measured from the last date a procedure was performed according to the patient's dental records.
4. Services beyond treatment that is considered the standard of care customarily provided, or which are not necessary to restore function, are considered "optional services."

If an enrolled person receives optional services, benefits may be provided based on the customary or standard procedure. A determination of optional services is not an opinion or judgment on the quality or durability of the service. The enrolled person will be responsible for any difference between the cost of optional services and any benefit payable.

5. Treatment of injuries or illness covered by Workers' Compensation or Employers' Liabilities Laws or services received without cost from any federal, state or local agencies are not a benefit.
6. Services for congenital or developmental malformations are not covered. Such malformations include, but are not limited to, cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), and fluorosis (a type of

discoloration of the teeth). Services provided to newborn children enrolled from birth for congenital defects or birth abnormalities are not, however, excluded from coverage.

7. Treatment to restore tooth structure lost from wear unless there is visible decay or fracture on the tooth structure is not covered.
8. Cosmetic surgery or procedures are not covered.
9. Prosthodontic services or any single procedure started before the patient is covered under the plan are not eligible for benefits.
10. Prescribed drugs, pain medications, desensitizing medications and therapeutic drug injections are not covered.
11. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dental or medical provider for treatment in any such facility are not covered services.
12. Extra oral soft tissue grafts (grafting of tissues from outside the mouth to oral tissues) or bone graft accession from a donor site are not a benefit.
13. Orthodontic services, or any services related to an Orthodontic treatment plan, are not covered unless stated in the Summary of Benefits.
14. Treatment of the temporomandibular joint disease (TMD) is not a covered expense.
15. Treatment must be provided by a licensed dentist or a person who by law may work under a licensed dentist's direct supervision.
16. A separate charge for office visits, non-diagnostic consultations, case presentations or broken appointments is not covered.
17. Treatment to correct harmful habits is not covered.
18. A separate charge is not allowed for behavior management, infection control, sterilization, supplies, and materials.
19. Charges for services or supplies that are not necessary according to accepted standards of dental practice are not benefits.
20. Charges for services, supplies, or devices which are not a dental necessity are not benefits.
21. Procedures considered experimental or investigational, as determined by Delta Dental, are not covered.
22. A hemisectioned tooth will not be benefited as two (2) separate teeth.
23. Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion is not a benefit.
24. Treatment to stabilize teeth is not a benefit.
25. Occlusal or athletic mouth guards are not a benefit.
26. Replacement of existing restorations for any purposes other than restoring active tooth decay or fracture are not covered.

27. Separate fees are not allowed for procedures, which are routinely considered by Delta Dental to be part of another service, if performed by the same dentist on the same date of service.

IV. COORDINATION OF BENEFITS

Coordination of benefits is the procedure used to pay health care expenses when a person is covered by more than one plan. The objective is to make sure the plans pay accurately as either "primary" or "secondary" so patient out-of-pocket expenses are reduced without the level of combined benefit payment under all plans exceeding the amount of the actual charges.

An enrolled person will provide Delta Dental with the necessary information needed to administer coordination of benefits. Delta Dental may release required information or obtain required information in order to coordinate the benefits of an enrolled person. Delta Dental has the right to recover the value of any benefits provided by Delta Dental which exceed its obligations under the terms of this provision from a dental provider, enrolled person, insurance company, or claims administrator to whom excess benefits were paid.

A. Medical and Dental Plans With Which Delta Dental Coordinates Benefits

1. Group contracts, health maintenance organization contracts, closed panel plans or other forms of group coverage, including non-insured plans and dental/medical benefits under group automobile contracts;
2. An insurance policy, a service plan contract, a pre-payment plan or other non-insured plan;
3. Medicare or any other governmental plan as permitted by law.

B. Medical and Dental Plans With Which Delta Dental Does Not Coordinate Benefits

1. Accidental injury policy provided through a school;
2. Hospital or other fixed indemnity coverage, accident or specified disease coverage, Medicare supplement policies or Medicaid policies;
3. Individual policies or contracts.

C. Which Plan is Primary?

To determine which plan is primary, Delta Dental considers both which enrolled member of a family is involved in a claim and the coordination provisions of the other plan. The primary plan will be determined based on the following:

1. Delta Dental is always the primary plan to any benefits payable by Medicaid or Indian Health Services.
2. Delta Dental is the secondary plan to a group medical plan providing benefits for dental related services including but not limited to: treatment due to accidental injuries, surgical extraction of impacted wisdom teeth, oral surgery and the administration of general anesthesia.
3. A plan that does not provide for coordination of benefits (non-coordinating plan) will pay its benefits first.

4. Enrollees Other Than Children

The plan covering the individual other than as a dependent (such as an employee or subscriber) is the primary plan. The plan covering the individual as a dependent is the secondary plan.

5. Children

When a child's dental care expenses are involved, Delta Dental follows the "birthday rule". The plan of the parent with the first birthday in a calendar year is always primary for the child. For example, if one parent's birthday is in January and the other parent's birthday is in March, the plan covering the parent born in January will be primary for the child.

If both parents have the same birthday, the plan that has covered a child the longest is the primary plan.

6. Children of Divorced or Separated Parents

If there is a court decree that establishes financial responsibility for dental coverage, the plan covering the child as a dependent of the parent with the court ordered financial responsibility shall be primary over any other plan covering the child.

If a court decree states that both parents are responsible for the dependent child's dental coverage, the provisions of paragraph five (5) (above) determine the order of benefits.

If a court decree states that the parents have joint custody without specifying that one parent has responsibility for dental coverage of the dependent child, the provisions of paragraph five (5) (above) determine the order of benefits.

If there is no court decree allocating responsibility for the dependent child's dental coverage, the order of benefits for the child are as follows:

- The plan covering the custodial parent;
- The plan covering the spouse of custodial parent;
- The plan covering the non-custodial parent; and then
- The plan covering the spouse of the non-custodial parent.

7. Continuation Coverage

If a person with mandated continuation coverage is covered under more than one plan, the plan providing continuation coverage shall be secondary.

8. If none of the provisions above apply, the plan which has covered the patient longer is primary.

D. How Delta Dental Pays as Primary

When Delta Dental is the primary plan, Delta Dental will pay the full benefit allowed as if there were no other coverage.

E. How Delta Dental Pays as Secondary

1. When Delta Dental is the secondary plan, payments will be based on the balance remaining after the primary plan has paid. Delta Dental will pay no more than that balance. In no event will Delta Dental pay more than it would have paid as primary.
2. Delta Dental will pay only for dental care expenses that are covered under this Contract.
3. Delta Dental will base the benefit payment on the allowable expense for the dental care involved.

V. CLAIMS APPEAL

A. Voluntary Appeal Procedure

An enrolled person may request a review of a claim by following Delta Dental's claim appeal procedures. All of Delta Dental's claim appeal procedures are voluntary and are designed to provide a full and fair review of any adverse benefit determination. An adverse benefit determination means a denial, reduction or termination of a benefit or a failure to make payment, in whole or in part, on a claim.

The decision as to whether to request a review or to appeal a claim will have no effect on the patient's right to any other benefits under the plan. In addition, the following provisions are assured. The enrolled person:

- will be notified in writing by Delta Dental of any adverse benefit determination and the reason(s) for the adverse determination;
- may submit written comments, documents, records, narratives, radiographs, clinical documentation and other information relating to the claim which Delta Dental will take into consideration, whether or not such information was submitted or considered in the initial benefit determination;
- shall be provided, upon request and free of charge, reasonable access to and/or copies of all documents, records and other information in the possession of Delta Dental that is relevant to the claim;
- may choose a representative to act on his or her behalf at the enrolled person's expense;
- will not be charged any fees or costs incurred by Delta Dental as part of the voluntary appeals process;
- has 180 days following receipt of a notification of an adverse benefit determination within which to appeal;
- will receive a response to the appeal from Delta Dental in writing within 30 days of receipt of the request;
- is not required to file an appeal prior to arbitration or taking civil action;
- is assured that the review of any adverse benefit determination under appeal will not be conducted by the same person or a subordinate of the person who determined the initial adverse benefit determination.

B. Informal Claim Review Process

Most claim-related requests may be handled informally by calling the Delta Dental Benefit Services Department at (505) 855-7111 or toll free at (877) 395-9420. Enrolled persons always have the opportunity to describe problems, submit explanatory information and allow Delta Dental to correct any errors quickly.

C. Formal Claim Appeal Process

If an enrolled person disagrees with a benefit determination, a formal review of the claim may be requested by filing an appeal with Delta Dental within 180 days following receipt of Delta Dental's notification of an adverse benefit determination. An appeal is a formal, written request to change a previous decision made by Delta Dental. There are two (2) types of appeals: Appeal of Claim Processing Procedure and Appeal of Claim for Dental Treatment.

1. **Appeal of Claim Processing Procedure** means the enrolled person is requesting a review of the application by Delta Dental of an administrative, procedural, or Contract/benefit provision which resulted in an adverse benefit determination.

An adverse benefit determination may be appealed by sending a request in writing to Delta Dental describing the reasons for requesting a review and including any additional information that the enrollee wishes to be considered.

A Delta Dental representative, who is neither the individual who made the initial claim determination nor the subordinate of such individual, will conduct a review of the claim. The results of the review will be provided in writing to both the enrolled person and to the treating dental provider, as appropriate.

2. **Appeal of Claims for Dental Treatment** is a request for a review of an adverse benefit determination that resulted from a clinical review conducted by a Delta Dental licensed dental consultant. Three voluntary options for appeal are available:

- The enrolled person may appeal an adverse benefit determination by sending a request in writing to Delta Dental, describing the reasons for the appeal and including any additional information the enrollee wishes to be considered. A licensed dental consultant, who is neither the individual who made the initial claim determination nor the subordinate of that individual, will provide a full and fair subsequent and independent review of the claim.

If the second consulting dentist determines the treatment was dentally necessary, Delta Dental will recalculate the claim for available benefits and send written notification of payment to the enrolled person and the treating dentist. In the event the second consulting dentist also determines the treatment was not dentally necessary according to the terms of the group Contract or standard dental treatment, the adverse benefit determination will be upheld. Delta Dental will send notification to the enrolled person and to the treating dental provider, as appropriate.

- The enrolled person may appeal an adverse benefit determination and request an independent oral examination by writing to Delta Dental, describing the reasons for the request, and including any additional information the enrolled person wishes to be considered. A licensed dental consultant, who has neither been involved in previous determinations of the claim under review nor is a subordinate of that individual, will provide a full and fair independent review of the claim.

If the second consulting dentist agrees the treatment was dentally necessary, Delta Dental will recalculate the claim for available benefits and send written notification of payment to the enrolled person and the treating dental provider, as appropriate.

In the event the second consulting dentist determines the treatment was not dentally necessary according to the terms of the group Contract or standard dental treatment, an oral examination will be scheduled with a mutually agreed upon licensed dentist. The fee for this oral examination will be the responsibility of Delta Dental and will not apply to the frequency limitations on exams under the group Contract benefit provisions. If that examining dentist agrees the treatment was dentally necessary, Delta Dental will recalculate the claim for available benefits and send written notification of payment to the enrolled person and the treating dentist. In the event the examining dentist determines the treatment was not dentally necessary according to the terms of the group Contract or standard dental treatment, the adverse benefit determination will be upheld. Delta Dental will send written notification to the enrolled person and to the treating dentist, as appropriate.

- The enrolled person may appeal an adverse benefit determination and request an external peer review by the local or state dental society. Delta Dental will provide the enrolled person with information on how to initiate the peer review process through the New Mexico Dental Association.

All written appeals must be directed to Delta Dental, Attention: Claims Manager, 2500 Louisiana Blvd. N.E., Suite 600, Albuquerque, New Mexico 87110.

VI. TERMINATION OF COVERAGE

A. When Coverage for an Enrolled Person Ends

Unless otherwise stated in the Summary of Benefits, coverage ends on the last day of the month for which premium is paid for an enrolled employee who loses coverage due to:

1. loss of eligibility;
2. voluntary cancellation of coverage;
3. cancellation of the contract by the Group or Delta Dental;
4. entering an unapproved leave of absence. Upon return to work, coverage may resume as specified by the Group and agreed to by Delta Dental. An employee absent from work due to an approved leave of absence, including those governed by the "Family Medical Leave Act of 1993", may continue coverage without interruption during a leave period if the Group continues to report the employee as an enrolled employee and premiums are paid on the employee's behalf.

An enrolled dependent loses coverage along with the enrolled employee, or on the last day of the month in which dependent status is lost, whichever is earlier. Coverage for dependents who reach age 25 will automatically be terminated by Delta Dental the last day of the month in which the dependent turns age 25 unless Delta Dental receives proof of the dependent's qualification for extended eligibility.

A subscriber and/or dependent(s) may be eligible to continue coverage depending on the size of the group and if certain conditions are met. Please refer to "Continuation of Coverage" in this handbook.

B. When Payment for Claims Ends

If an enrolled person loses coverage, Delta Dental will only pay claims for covered services incurred prior to the loss of coverage. To be considered for payment, claims must be submitted to Delta Dental in writing within 12 months after the services have been provided and for which benefits are payable.

C. Termination of Coverage for Group's Failure to Pay Premium

Delta Dental will only provide benefits for claims submitted on enrolled persons as long as the Group has paid the premium to Delta Dental for the period in which the services were performed.

VII. CONTINUATION OF COVERAGE

A Group may be subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. This means that enrolled persons may be entitled to continue coverage at their own expense under this dental plan following certain qualifying events if certain conditions are met. To be eligible for continued coverage, the enrolled person must be enrolled in the plan on the day before the qualifying event occurs. The Group is responsible for providing enrolled persons with notification of COBRA continuation rights and for any/all administration related to those COBRA rights.

VIII. ERISA

This group dental plan may be subject to the Employee Retirement Income Security Act of 1974 (ERISA), which provides for certain rights and protections. When applicable, the Group is responsible for providing enrolled persons notification of ERISA rights.

IX. NOTICE OF PRIVACY PRACTICES

This section describes how Delta Dental protects the medical information of enrolled persons. Delta Dental understands that medical and health information is private and is committed to protecting the confidentiality and security of that information.

Delta Dental is required to provide this notice by law, specifically, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Delta Dental must:

- make certain to maintain the privacy of each enrolled person's Protected Health Information;
- provide this notice of our legal duties and privacy practices with respect to Protected Health Information;
- follow the terms of the notice that is currently in effect, and
- describe an enrolled person's rights with respect to Protected Health Information and how enrollees can exercise those rights.

This notice was effective April 14, 2003 and will remain in effect until amended.

Protected Health Information is information that may identify an enrolled person and relate to the past, present or future health, treatment, or payment for health care services for that enrollee. This notice applies to all of the medical records maintained by Delta Dental. An individual's dentist may have different policies or notices regarding the dentist's use and disclosure of medical information created in the dentist's office.

Delta Dental safeguards Protected Health Information from inappropriate use or disclosure. Delta Dental employees, and those of companies that help Delta Dental service the dental plan, are required to comply with Delta Dental requirements that protect the confidentiality of Protected Health Information. Delta Dental will not disclose Protected Health Information to any other company or person for their use in marketing their products to any individual without the expressed permission of that individual. However, as described in this notice, Delta Dental will use and disclose Protected Health Information about an enrolled person for business purposes to administer the dental plan and when required or authorized by law.

For answers to questions about this notice, contact:

Delta Dental of New Mexico
HIPAA Privacy Office
2500 Louisiana Blvd. NE, Suite 600
Albuquerque, NM 87110
505-883-4777
800-999-0963

This Notice of Privacy Practices is also available on the Delta Dental website:
www.deltadentalnm.com

A. How Delta Dental May Use and Disclose Protected Health Information

The following categories describe different ways that Delta Dental is permitted to use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways Delta Dental is permitted to use and disclose information will fall within one of the categories.

1. **Payment:** Delta Dental may use and disclose Protected Health Information to determine eligibility for plan benefits, to make benefit payments for the treatment and services received from dentists, to determine benefit responsibility under the plan, to issue premium billings and to coordinate plan coverage. For example, the medical information contained on claims may be used to reimburse dentists for their services. Delta Dental may tell an enrolled person's dentist about dental history to determine whether the plan will cover treatment. Delta Dental may also disclose Protected Health Information to other insurance carriers to coordinate benefit payments with respect to a particular claim.
2. **Health Care Operations:** Delta Dental may use and disclose Protected Health Information as necessary for company operations. For example, Delta Dental may use medical information in connection with: providing customer service, establishing premiums and underwriting rules, evaluating a request for dental benefit products, administering those products, quality assurance, professional review, and processing transactions requested by an enrolled person. Delta Dental may also disclose Protected Health Information to Delta Dental affiliates, and to business associates outside of Delta Dental, if those affiliates or associates need to receive Protected Health

Information to provide a service to Delta Dental and will agree to abide by specific rules relating to the protection of Protected Health Information. Examples of business associates are data processing companies, insurance agents, attorneys, auditors or companies that furnish administrative support or services.

3. **Health-Related Benefits or Services:** Delta Dental may use Protected Health Information to provide an enrolled person with information about benefits available under the dental plan.
4. **Incidental Disclosures:** Certain incidental disclosures of Protected Health Information occur as a byproduct of lawful and permitted use and disclosure of Protected Health Information. These incidental disclosures are permitted if Delta Dental applies reasonable safeguards related to Protected Health Information.
5. **Others Involved in an Enrolled Person's Healthcare:** Unless an enrolled person objects, Delta Dental may disclose Protected Health Information to a member of the enrolled person's family, a relative, or any other person specifically identified, that directly relates to that person's involvement in the enrolled person's health care or payment for health care. If the enrolled person is unable to agree or object to such a disclosure, Delta Dental may disclose such information as necessary in an emergency or if Delta Dental determines that it is in best interest of the enrolled person based on professional judgment.
6. **As Authorized by an Enrolled Person:** Other uses and disclosures of Protected Health Information not covered by this notice and permitted by the laws that apply to Delta Dental will be made only with an enrolled person's written authorization or that of a legal representative. An enrolled person may authorize Delta Dental to use Protected Health Information or disclose it to another person for a designated purpose. An enrolled person may withdraw the authorization in writing at any time, except to the extent that Delta Dental has taken action relying on the prior authorization, i.e., Delta Dental cannot take back any disclosures already made with authorization.
7. **Authorized by Law for Public Benefit:** Delta Dental may use or disclose Protected Health Information as authorized by law for the following purposes deemed to be in the public interest:
 - as required by law;
 - to avert a serious threat to health or safety;
 - to report to federal, state or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations;
 - for public health activities including reporting births and deaths, victims of abuse or neglect, reaction to medications or problems with products and to prevent or control disease, injury or disability;
 - to a coroner, medical examiner or funereal directors to assist in identifying a deceased individual or to determine the cause of death. Delta Dental may also release Protected Health Information for organ donation purposes;
 - in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process;

- to federal officials for intelligence, counterintelligence, and other national security activities authorized by law;
- as authorized to comply with workers' compensation laws and other similar legally established programs;
- if an enrolled person is an inmate of a correctional institution or under the custody of law enforcement officials, Delta Dental may release medical information about that enrollee to the correctional institution or law enforcement official; and in response to a court or administrative order if the enrollee or the enrollee's estate is involved in a lawsuit or a dispute. Delta Dental may also disclose Protected Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell the enrollee about the request or to obtain an order protecting the Protected Health Information requested. Delta Dental may disclose Protected Health Information to any governmental agency or regulator with whom the enrolled person has filed a complaint or as part of a regulatory agency examination.

B. Individual Rights Regarding Protected Health Information

The following rights concerning Protected Health Information apply under HIPAA.

An enrolled person may contact Delta Dental at the location listed in this notice to submit a request or for an explanation on how to submit a request, obtain forms, or other additional information.

1. **Right to Inspect and Copy Protected Health Information:** In most cases, an enrolled person has the right to inspect and obtain a copy of his or her Protected Health Information maintained by Delta Dental. To inspect and copy Protected Health Information, an enrollee must submit a request in writing. If a copy of Protected Health Information is requested, a fee may be charged for the costs of copying, mailing or other supplies associated with the request. However, certain types of Protected Health Information will not be made available for inspection and copying. This includes Protected Health Information collected by Delta Dental in connection with, or in reasonable anticipation of any claim or legal proceeding. In very limited circumstances Delta Dental may deny a request to inspect and obtain a copy of Protected Health Information. A review of that denial may be requested. An individual chosen by Delta Dental who was not involved in the original decision to deny the request will conduct the review. Delta Dental will comply with the outcome of that review.
2. **Right to Amend Protected Health Information:** If an enrolled person believes his or her Protected Health Information is incorrect or that an important part of it is missing, the enrollee has the right to ask Delta Dental to amend the Protected Health Information while it is kept by or for Delta Dental. This request, and the reason for the request, must be submitted in writing. Delta Dental may deny the request if it is not in writing or does not include a reason that supports the request. In addition, Delta Dental may deny the request if it is to amend Protected Health Information that (a) is accurate and complete; (b) was not created by Delta Dental, unless the person or entity that created the information is no longer available to make the amendment; (c) is not part of the Protected Health Information kept by or for Delta Dental; or (d) is not part of the Protected Health Information which would be permitted to inspect and copy.

3. **Right to a List of Disclosures:** An enrolled person has the right to request a list of the disclosures Delta Dental has made of his or her Protected Health Information. This list will not include disclosures made (a) for treatment, payment, health care operations, (b) for purposes of national security, law enforcement or to corrections personnel, (c) made pursuant to person's authorization or (d) made directly to the enrolled person. The request must be submitted in writing and state the time period applicable to the list of disclosures. The time period may not be longer than six years and may not include dates before April 14, 2003. The request should indicate in what form the list is requested (for example, on paper or electronically). The first list requested within a 12-month period will be free. Delta Dental may charge the individual making the request for responding to any additional requests. Delta Dental will identify the cost involved and the individual making the request may choose to withdraw or modify the request before any costs are incurred.
4. An enrolled person has the right to request a restriction or limitation on Protected Health Information used or disclosed for treatment, payment or health care operations, or request disclosure to someone who may be involved in the care or payment of his or her care, such as a family member. To request a restriction, an enrollee must send the request in writing and tell Delta Dental (1) what information should be limited; (2) whether the limitation would apply to Delta Dental use, disclosure or both; and (3) to whom the limits would apply (for example, disclosures to a spouse or parent). While Delta Dental will consider the request, Delta Dental is not required to agree to it. Delta Dental will not agree to restrictions on Protected Health Information uses or disclosures that are legally required, or which are necessary to administer Delta Dental business.
5. **Right to Request Confidential Communications:** An enrolled person has the right to request that Delta Dental communicate Protected Health Information in a certain way or at a certain location if the enrolled person informs Delta Dental that communication in another manner may endanger the enrolled person. For example, the enrolled person may request that Delta Dental only makes contacts at work or by mail. To request confidential communications, a request must be sent in writing, which specifies how or where you wish to be contacted. Delta Dental will accommodate all reasonable requests.
6. **Right to Receive a Copy of the Notice:** An enrolled person may request a copy of our notice at any time by contacting the Privacy Office or by using the website, deltadentalnm.com. If this notice is obtained via the web site or by electronic mail, the enrolled person is also entitled to request a paper copy.
7. **Right to File a Complaint:** If an enrolled person believes his or her privacy rights have been violated, he or she may file a complaint with Delta Dental or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. There will not be any penalty for filing a complaint. For answers to questions as to how to file a complaint please contact Delta Dental at (505) 883-4777, (800) 999-0963 or HIPAAprivacy@ddpnm.com.

C. Additional Information

Changes to This Notice: Delta Dental reserves the right to change the terms of this notice at any time. Delta Dental reserves the right to make the revised or changed notice effective for Protected Health Information previously received as well as any Protected Health Information received in the future. The effective date of this notice and any revised or changed notice will be included in the

notice. Enrolled persons will receive a copy of any revised notice from Delta Dental by mail or by e-mail, but only if e-mail delivery is offered by Delta Dental and the enrolled person agrees to such delivery.

Further Information: There may have additional rights under other applicable laws. For additional information regarding the Delta Dental HIPAA Medical Information Privacy Policy or general Delta Dental privacy policies, please contact Delta Dental at HIPAAprivacy@ddpnm.com, (505) 883-4777, (800) 999-0963 or write to:

Delta Dental of New Mexico
HIPAA Privacy Office
2500 Louisiana Blvd., NE, Suite 600
Albuquerque, NM 87110

X. DEFINITIONS

Allowed Amount: the Maximum Approved Fees determined by Delta Dental and considered for each dental procedure before application of copayment and deductible.

Benefit Period: the time period for accumulating the deductible, the benefit maximum and the time during which frequency limitations apply, as shown in the Summary of Benefits

Benefits: the amount Delta Dental will pay for covered dental services described in Section III, "Benefits, Limitations, and Exclusions," and in the Summary of Benefits.

Contract: the Group Dental Insurance Contract document, including Article I "Declarations," Dental Benefit Handbook, the Summary of Benefits and successor agreements, or renewals now or hereafter issued or executed.

Copayment: the percentage of the dental provider's approved fee due from the enrolled person to the dental provider.

Deductible: the amount an enrolled person or family must pay toward covered services before Delta Dental makes any payment for those covered services.

Delta Dental: Delta Dental of New Mexico or Delta Dental Plan of New Mexico, Inc.

Dental Necessity: a service or supply provided by a dentist or other provider that has been determined by Delta Dental as generally accepted dental practice for the enrolled person's diagnosis and treatment. Delta Dental may use dental consultants to determine generally accepted dental practice standards and if a service is a dental necessity. These services or supplies are in accordance with generally accepted local and national standards of dental practice, and not primarily for the convenience of the enrolled person or provider. The services/supplies are the most appropriate that can safely be provided. The fact that a provider has performed or prescribed a service or supply does not mean it is a dental necessity.

Dentist: a duly licensed dentist, legally entitled to practice dentistry at the time and in the place services are provided.

Eligible Dependent: a person who meets the conditions of dependent eligibility outlined in Section I, "Eligibility and Enrollment," whether or not actually enrolled.

Eligible Employee: an employee who meets the conditions of employee eligibility outlined in Section I, "Eligibility and Enrollment," whether or not they actually enroll.

Enrolled Dependent: an eligible dependent whose completed enrollment information has been received and approved by Delta Dental, and for whom applicable premium is paid.

Enrolled Employee: an eligible employee whose completed enrollment information has been received and approved by Delta Dental, and for whom applicable premium is paid.

Enrolled Person: an enrolled employee, enrolled dependent, COBRA-enrolled person, or other individual who meets the conditions of eligibility outlined in Section I, "Eligibility and Enrollment," whose completed enrollment information has been received and approved by Delta Dental and for whom applicable premium is paid.

Experimental/Investigational: a treatment, procedure, facility, equipment, drug, device or supply that is not accepted as standard dental treatment for the condition being treated or any items requiring Federal or other governmental agency approval if such approval had not been granted at the time services were rendered. To be considered standard dental practice and not Experimental/Investigational, the treatment must have met all five of the following criteria:

1. A technology must have final approval from the appropriate regulatory governmental bodies;
2. The scientific evidence as published in peer-review literature must permit conclusions concerning the effect of the technology on health outcome;
3. The technology must improve the net health outcome;
4. The technology must be as beneficial as any established alternatives; and
5. The technology must be attainable outside the investigational settings.

Maximum: the highest level of the total dollars payable by Delta Dental for covered dental services in a benefit period or lifetime period for each enrolled person.

Maximum Approved Fee: the amount above which a Delta Dental patient may not be charged for a dental service received from a participating provider.

Medical Necessity: a disease, injury or illness exists which would prohibit the safe delivery of standard dental treatment. Treatment, services, and supplies are not medically necessary if made or delivered solely for the convenience of the enrolled person or provider. The fact that a provider has performed or prescribed a procedure or treatment does not mean it is medically necessary. Delta Dental may use dental consultants to determine if a service is a medical necessity.

Non-Participating Approved Amount: the fee for a single procedure, determined by Delta Dental, for the purpose of calculating payment to a non-participating dentist.

Non-Participating Dentist: a dentist who does not participate in any of Delta Dental's provider networks.

Open Enrollment: a period of time specified by the Group to allow eligible persons to enroll in the plan or to cancel coverage under the plan for the renewed benefit period.

Participating Dentist: a dentist who has agreed to abide by a Delta Dental Participating Dentist Agreement.

Predetermination of Benefits: an advance estimate of benefits payable under the plan as requested by the dental provider prior to performing a recommended treatment for a covered person. A predetermination of benefits is subject to all maximums, deductibles, eligibility and all other plan provisions at the time services are actually performed. A predetermination of benefits is not required as a condition for payment of benefits.

Premium: the monthly amount due to Delta Dental for enrolled persons.

Provider: a legally licensed dentist, or any other legally licensed dental practitioner, rendering services within the scope of that practitioner's license.

Services and Supplies: those services, devices, or supplies that are considered safe, effective, and appropriate for the diagnosis or treatment of the existing condition. Covered services and supplies do not include experimental services, devices, or supplies. For the purposes of this plan, Delta Dental reserves the right to make the final decision as to whether services, supplies or devices are experimental under this definition.

Sound Natural Teeth: those teeth that are either primary (A through T or AS through TS) or permanent (1 through 32 and 51 through 82) dentition that have adequate hard and soft tissue support.

Subscriber: the enrolled person, such as an employee, who is not enrolled as a dependent.



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