



**Delta Dental of Colorado
PO Box 173803
Denver, Colorado 80217**

DELTA DENTAL BENEFITS CONTRACT

The parties of this Contract are BOULDER VALLEY SCHOOL DISTRICT, RE-2, herein called the "Group," "Applicant," or "Employer" and Delta Dental of Colorado, herein called "Delta Dental." The attached appendices and riders constitute the entire Contract of the parties and will become binding upon the parties and their respective successors and assigns effective the first day of July, 2024 for a two-year period and for successive one-year periods thereafter unless terminated as herein provided. This Contract is issued and delivered in the state of Colorado, is governed by the laws of Colorado, and is subject to the terms and conditions recited on the subsequent pages of this contract, and may not be changed, altered, or terminated except in accordance with Article VIII, TERMINATION/NONRENEWAL/CONTINUATION of this Contract.

This DECLARATIONS PAGE supersedes any contrary provision of the subsequent sections of this contract.

DECLARATIONS PAGE

Group: BOULDER VALLEY SCHOOL DISTRICT, RE-2

Type of Contract: Delta Dental PPO

Group Number: #1996

Contract Group Effective Date: July 1, 2024

Contract Anniversary Date: July 1st

**SCHEDULE OF BENEFITS
(Who Pays What)**

	Delta Dental PPO™ Provider	Delta Dental Premier® Provider	*Non- Participating Provider
Covered Services	Plan Pays	Plan Pays	Plan Pays
Diagnostic & Preventive Services			
Oral Exams and Cleanings	100%	75%	75%
X-Rays			
Sealants			
Fluoride Treatment			
Basic Services			
Basic Restorative (Fillings)	80%	75%	75%
Oral Surgery			
Endodontics (Root Canal Therapy)			
Periodontics (Gum Disease Treatment)			
Major Services			
Prosthodontics (Dentures, Bridges)	60%	50%	50%
Special Restorative (Crowns, Implants, and Onlays)			
TMJ Services			
Temporomandibular Joint Therapy	50%	50%	50%
Orthodontic Services			
Orthodontics (dependent child to age 19)	60%	50%	50%

***Important: Non-Participating Providers are allowed to balance-bill. Subscribers and/or Dependents are responsible for the difference between the Non-Participating Maximum Plan Allowance and the full fee charged by the Provider.**

Age

Type	Age Limit	Coverage Thru
Dependent Child	26	Month
End Dependent Ortho	19	Month

Deductible (July 1st–June 30th)

Class	Type	*Network	Amount
Orthodontic Class Only	Individual Lifetime	Premier & Non-Participating	\$100

Annual Maximum (July 1st–June 30th)

Class	Type	*Network	Amount
All Covered Classes Except D&P, Ortho, & TMJ	Individual coverage amount	PPO, Premier & Non-Participating	\$1500
Orthodontic Classes	Individual Lifetime	PPO, Premier & Non-Participating	\$1250
TMJ Classes	Individual Lifetime	PPO, Premier & Non-Participating	\$1000

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

Enrollment Type

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

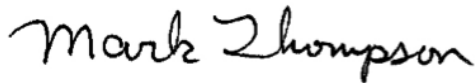
Where two individuals who are spouses and are both eligible for coverage under this contract, they may be enrolled together or separately, but not both. Dependent children may only be enrolled under one parent. The term spouse includes a civil union partner or a domestic partner.

Rate Coverage

Coverage Tier	Admin Fee
PER MONTH PER SUBSCRIBER	\$ 3.98

This Service Fee is contingent upon total enrollment of all eligible primary subscribers, in accordance with the eligibility provisions in Article I. Should enrollment vary by 10% or more, Delta Dental reserves the right to recalculate the Service Fee based upon actual enrollment. The change in Service Fee would not become effective until the next contract anniversary. If a recalculation becomes necessary, multiple-year contracts will be replaced with a new agreement based upon the new enrollment.

The Service Fee is due the 15th day of the following month for the Weekly, and as further described in Article VII. The Monthly Claims Reimbursement and Admin fees are Due on the 15th of the following month and as further described in Article VII.

Riders or Appendices Attached**Countersigned:****Delta Dental of Colorado**

Signature

April 12, 2024
Date

Accepted:**BOULDER VALLEY SCHOOL DISTRICT, RE-2 - #1996**

Signature

Date

Delta Dental of Colorado Group Dental Plan

CONTACT US

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

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

**Delta Dental of Colorado
PO Box 173803
Denver, CO 80217**

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

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ARTICLE I. ELIGIBILITY

1.01 ELIGIBILITY. Subject to eligibility rules set forth in Section 1.02 below and/or on the Declarations Page. They may also enroll during an Open Enrollment period if offered by the employer.

a) **BECOMING COVERED.** Delta Dental must receive enrollment data for each Subscriber in a format acceptable to Delta Dental. The enrollment data must be received within 31 days of a Subscriber or Dependent's enrollment. The enrollment data must include the Subscriber's address, gender, social security number, date of birth, and member effective date. If the Subscriber chooses to enroll Dependents, each Dependent's name (including surname if different from Subscriber's), relationship to the Subscriber, address, gender, Social Security number, and date of birth must be submitted.

- A Subscriber not enrolled in the Plan may not enroll Dependents.

b) **ENROLLMENT TYPE.** The Group's enrollment type is Open Enrollment. A Subscriber who fails to enroll within the period described in Article I, Section 1.01(a) may enroll at the next Open Enrollment.

c) **MAINTAINING COVERAGE.** The Group will give Delta Dental a list of any Plan additions, changes, or terminations on or before the first day of each month. Delta Dental is not required to provide Benefits for a Subscriber or Dependent not on the list or for whom the monthly Premium is not paid.

1.02 SUBSCRIBER ELIGIBILITY (OPEN ENROLLMENT). Subscribers may enroll within 31 days of the date they first become eligible.

- a) Eligible Subscribers who do not enroll as described above may enroll during Open Enrollment. Eligible Subscribers who enroll and later drop the Plan may enroll only during Open Enrollment.
- b) Eligible Subscribers who lose coverage through another source may enroll with proof of loss. (Loss of coverage is defined as loss due to death, divorce, job loss, or termination of benefits by the employer.) They must enroll within 31 days of the loss of coverage.

1.03 DEPENDENT ELIGIBILITY (OPEN ENROLLMENT). Dependents of an eligible Subscriber may enroll within 31 days of the following:

- The date the Subscriber becomes eligible to enroll. The effective date is that of the Subscriber.
- New Dependents must be enrolled within 31 days and will be covered the first of the following month. Newborns and adopted children will be covered on the date of birth or date of placement for adoption.
- The date the Contract is amended to provide Dependent coverage. The Plan becomes effective on the first day of the month following this change.

- a) New Dependents must be added within 31 days. If not added during this time, the Dependent can be added during the Open Enrollment period.
- b) Eligible Dependents who do not enroll as described above may enroll only during the Open Enrollment period. Dependents who enroll and later drop the Plan may enroll only during Open Enrollment.
- c) Eligible Dependents who lose coverage through another source may enroll with proof of loss. (Loss of coverage is defined as loss due to death, divorce, loss of job, or termination of benefits by the employer.) They must enroll within 31 days of the loss.

1.04 TERMINATION OF COVERAGE. A Member's Plan will terminate at the earliest of:

- The date Delta Dental receives a written request to cancel;
- The date the Subscriber is not eligible for coverage;
- The date the Contract terminates;
- The end of the period for which Premium is paid;
- The date the Member enters full-time military service of any country; or
- As to any Dependent, the date the person no longer qualifies as a Dependent.

Delta Dental must be notified within 60 days if a Member is no longer eligible.

Family and Medical Leave ACT (FMLA)

If coverage ends during an employer-approved FMLA leave, coverage may be reinstated upon return to work within the terms of the FMLA leave. Pre-existing conditions, limitations, and other waiting periods will not be imposed unless they were in effect for the Subscriber and/or his or her Dependents when coverage terminated.

1.05 INVOLUNTARY LOSS OF COVERAGE DUE TO STRIKE, LEAVE OF ABSENCE, OR LAYOFF. If a Subscriber loses coverage due to strike, layoff, or leave of absence and returns to work within six months, he may re-enroll on the first day of the month after his return to work. If the absence exceeds six months, he will be treated as a new Subscriber. Contract provisions relating to the Deductible, Coinsurance, Contract Year Maximum, and Waiting Periods, if any, will apply as to new coverage. The following exception applies:

Delta Dental of Colorado complies with the Uniformed Services Employment and Reemployment Rights Act (USERRA). Subscribers called to active duty may enroll as if there had been no leave of absence if they are still in an Eligible Class of Subscriber when they return to work. USERRA allows Subscribers to elect continuation of coverage when coverage would terminate due to an absence to serve in the uniformed services.

Services received by a person who is not eligible due to leave of absence are not covered unless the person elects continued coverage as provided in Article VIII or according to USERRA where applicable.

- 1.06 INVOLUNTARY LOSS OF “OTHER COVERAGE.”** A person who loses dental coverage from another source will be allowed to enroll with proof of the loss. (Loss of coverage is defined as loss due to death, divorce, loss of job, or termination of benefits by the employer.) The person must enroll within 31 days of the loss. Coverage will begin the first day of the month following enrollment.
- 1.07 VOLUNTARY TERMINATION OF COVERAGE (OPEN ENROLLMENT).** A Subscriber who cancels their Plan may only re-enroll at the next Open Enrollment.
- 1.08 REVIEW OF RECORDS.** Applicant will permit Delta Dental, with advance written notice, to inspect records of Applicant in order to confirm the lists of Members prepared by Applicant. Delta Dental may verify Applicant's compliance with Article VII. Delta Dental may use auditors or other agents for this purpose.

ARTICLE II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

- 2.01 PARTICIPATING PROVIDERS.** Delta Dental will make reasonable efforts to provide Applicant a list of Participating Providers. The list may be provided in different formats. The Providers may change from time to time, and Delta Dental reserves the right to change the list without prior notice to the Applicant.

Neither Delta Dental nor Applicant is liable for any act or omission by Providers or their agents or employees who provide or contract to provide dental Services under this Contract. Providers who participate with Delta Dental are independent contractors. They are neither agents nor employees of Delta Dental. Nor is Delta Dental an agent or employee of any Participating Provider. Delta Dental will not be responsible for any claim or demand for damages arising out of any injuries suffered by a Member while receiving care from any Participating Provider or in any Participating Provider's facilities.

- 2.02 HOW TO FIND A PROVIDER.** There are two easy ways for Members to find out if a Provider is a Delta Dental PPO or Premier Participating Provider.
- **Visit our website at www.deltadentalco.com** or
 - **Phone our automated call center at 1-800-610-0201.**

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

- 2.03 AVAILABILITY OF PROVIDER.** A Member may elect the Service of any licensed Provider, but neither Delta Dental nor Applicant guarantees the availability of any Provider.
- 2.04 APPROVAL OF BENEFITS.** Members need not obtain approval before being treated. Before starting treatment that may cost \$400 or more, Members should request an estimate from Delta Dental. Pre-treatment estimates are not required.

ARTICLE III. BENEFITS AND COVERAGE (What is Covered)

Subject to the limitations and exclusions included in this Contract, the Completed dental Services are Benefits when provided by a Provider (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 based on the terms of this Contract and Delta Dental's processing policies.

DIAGNOSTIC & PREVENTIVE SERVICES

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

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

PROCEDURE	BENEFIT DESCRIPTION
Oral Exam (all exam types, Including Limited Oral Exam – Problem Focused)	Two exams in a contract year are covered. There is no separate benefit for diagnosis, treatment planning, or consultation by the treating Provider.
Bitewing X-rays	Covered once in a contract year or limited to the allowance for a full-mouth survey. Not separately benefited 6 months after full-mouth survey. Limit two bitewing images for patients under age 10.
Full-mouth Survey or Panoramic X-ray	Covered once in a 60-month period.
Individual Periapical X-rays Intraoral Occlusal X-rays	Limited to the allowance for a full-mouth survey.
Dental Cleaning	Two cleanings or any procedure that includes any component of a cleaning in a contract year are covered.
Sealants or Preventive Resin Restoration	Covered one time per tooth in a 36-month period. Allowed for the occlusal (chewing) surface of decay-free unrestored permanent molars. Covered for Dependent Children through age 14. There is no separate benefit for preparation of the tooth or any other procedure associated with the sealant application.
Fluoride Treatment	Covered once per contract year for Dependent Children through age 15.
Caries Risk Assessment	Covered once per contract year. Not covered under age 3.
Space Maintainer	Covered once per quadrant per lifetime through age 13 to maintain space left by prematurely lost baby back teeth.
Palliative Treatment	Covered as a separate benefit only if no other service is provided during the visit except an exam and/or X-rays.
Oral Pathology Lab Procedures	Covered with a pathology report.

BASIC SERVICES

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

PROCEDURE	BENEFIT DESCRIPTION
Amalgam Fillings (silver fillings) and Composite Resin (white plastic) Fillings	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing filling is allowed if at least 12 months have passed since the existing filling was placed.
Interim Therapeutic Restoration	Covered once per tooth per lifetime for baby teeth.
Protective Filling	Covered once per 12-month period per tooth for emergency relief of pain if no other restorative service is performed on the same tooth on the same date.
Pin Retention	Covered with a basic (amalgam or composite) filling. A benefit one time per filling.
Stainless Steel Crowns Resin Crowns	Covered once per 12-month period per tooth when that tooth cannot be restored by a filling.

BASIC — ENDODONTIC SERVICES

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

Therapeutic Pulpotomy	Covered once per tooth per lifetime for baby teeth.
Root Canal Therapy	Covered once per tooth. Includes working and final X-rays, cultures, tests, local anesthesia, and routine follow-up care.
Repeat Root Canal Therapy	Covered if at least 24 months have passed since the first root canal procedure on the same tooth was performed. Includes working and final X-rays, cultures, tests, local anesthesia, and routine follow-up care.
Apexification/Recalcification (apical closure/calcific repair of perforations, root resorption, etc.)	Covered once per tooth per lifetime. A course of treatment includes initial, interim, and final visits. Includes working and final X-rays, cultures, tests, local anesthesia, and routine follow-up care.
Apicoectomy	Covered once per root per 24 months. Includes working and final X-rays, cultures, tests, local anesthesia, and routine follow-up care.
Retrograde Filling (per root)	Covered once per root per 24-month period. Includes working and final X-rays, cultures, tests, local anesthesia, and routine follow-up care.
Root Amputation (per root)	Includes working and final X-rays, cultures, tests, local anesthesia, and routine follow-up care.
Hemisection (includes any root removal)	Includes working and final X-rays, cultures, tests, local anesthesia, and routine follow-up care.

BASIC — PERIODONTIC SERVICES

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

Periodontal Scaling and Root Planing — Per Quadrant	Covered once per quadrant per 24-month period. If less than a full quadrant meets criteria for coverage, benefits will be based on the fee for a partial quadrant.
Periodontal Maintenance Procedures Following Active Therapy	Periodontal maintenance procedures, in combination with adult and Dependent Child cleanings or scaling in the presence of gingival inflammation procedures, are limited to two in a contract year.
Crown Lengthening — Hard Tissue, by Report	Included when performed on the same date as surgery to bone structures, crown preparation, or other restoration. Benefits are based on clinical review and limited to once in 36 months.
Osseous Surgery, Gingivectomy, Gingival Flap Procedure, Guided Tissue Regeneration (includes surgery and re-entry), Pedicle Soft Tissue Graft, Free Soft Tissue including donor site	Periodontal surgical procedures are covered once per quadrant per 36-month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Includes local anesthesia and routine post-operative care. Benefits are based on clinical review.

BASIC — ORAL SURGERY SERVICES

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

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

BASIC — PAIN MANAGEMENT SERVICES

General Anesthesia, Analgesia (Nitrous Oxide), I.V. Sedation	Only one type of anesthesia procedure per date of service is allowed as a separate benefit when provided for covered Oral Surgery procedures.
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MAJOR — ADJUSTMENT AND REPAIR SERVICES

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

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

Denture Adjustments	Covered after six months from the insertion of the full or partial denture, and then not more than two adjustments per appliance per 12-month period.
Repairs to Full and Partial Dentures	Covered after six months from the insertion of the full or partial appliance.
Tissue Conditioning per Denture	Covered twice per 36-month period per appliance.
Relining Dentures or Rebasing Dentures	Relining or rebasing is covered at least six months after the initial insertion of a full or partial denture and then not more than once per 36-month period per appliance.

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

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

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

Inlays	An Alternate Benefit allowance for an amalgam filling will be made for the same number of surfaces. Any difference in fee is chargeable to the patient. It will be covered at the amalgam filling allowance only if 60 months have passed since the last placement. Not covered for Dependent children under age 12.
Onlays, Crowns (single unit), Veneers	Covered once per 60-month period for the same tooth. Not covered under age 12. Benefits based on clinical review.
Core (Crown) Buildup including any Pins, Post and Core	Covered when needed to retain a special restorative service or prosthodontic service and only when need is due to extensive loss of tooth structure caused by decay or fracture. Post and core is covered only for endodontically treated teeth. Covered only if 60 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for Dependent children under age 12. Benefits based on clinical review.
Implants — Surgical Placement and Restoration	The placement of the surgical implant and placement of a crown, full or partial denture, or bridge over the implant, is covered once in a 60-month period for restorations involving the same tooth. This limitation includes any prior Special Restorative or Prosthodontic benefits for the same tooth. Not covered for Dependent children under age 16. Temporary appliances are not separately payable.

MAJOR — PROSTHODONTIC SERVICES

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

Fixed Bridges	Covered once per 60-month period per individual unit and only if 60 months have passed since the last special restorative, prosthodontic, or implant benefit for the same tooth/teeth. Not covered for Dependent children under age 16.
Full Dentures	Covered once per 60-month period per arch. Not covered within 60 months of benefit for a partial denture in the same arch. Personalized denture procedures, overdentures, or associated procedures are not covered.
Partial Dentures	Covered once per 60-month period per arch. Includes any clasps and rests and all teeth. Metal-based partial dentures are not covered under age 16.
Temporary Removable Partial Dentures	Payable for children 16 years of age or under for missing anterior permanent teeth.
Occlusal Guard	Covered once per 36-month period for bruxism (grinding). Adjustments are covered once per year following six months of initial placement.

TMJ SERVICES

PROCEDURE

BENEFIT DESCRIPTION

TMJ Treatment	TMJ Services are defined as treatment by a licensed Dentist for the pain/dysfunction of the Temporomandibular Joint or myofascial pain/dysfunction syndrome. Benefits include services to diagnose, prevent or intercept TMJ syndrome and are limited to Diagnostic services, Occlusal Orthotic appliance (including any adjustments), Occlusal adjustment of teeth and Occlusal analysis.
Limitations on TMJ Benefits	No benefits will be provided for: • Replacement or repair of appliances; • Services that would normally be provided as medical care. Examples include, but are not limited to, psychotherapy, special joint or neuromuscular exams, x-rays, joint surgery, special analyses or instrumentation.

ORTHODONTIC SERVICES

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

ARTICLE IV. LIMITATIONS/EXCLUSIONS
(What is Not Covered and Pre-Existing Conditions)

LIMITATIONS

- a) Alternate Benefits — Often more than one service or supply can be used for treatment. In deciding the amount allowed on a claim, plan will consider other materials and methods of treatment. Payment will be limited to the Covered Amount for the least costly covered service that meets accepted standards of dental care as determined by Delta Dental. The covered person and their Provider may decide on a more costly treatment. Delta Dental will pay toward the cost of the selected procedure using the Coinsurance level shown on the Schedule of Benefits. Payment will be limited to the Covered Amount for the least costly treatment. **Only covered services are eligible to receive alternate benefits.**
- b) Temporary services will be covered as part of the final service. The benefit allowed for such service and the final service is limited to the benefit allowed for the final service.
- c) Plan will pay procedures performed at the same time and as part of a primary procedure at the amount allowed for the primary procedure.
- d) Services are covered when provided by a person legally permitted to perform such services and are determined to be necessary and appropriate. Benefits will be based on the terms of this plan and Delta Dental's Processing Policies, even if no monies are paid.
- e) Pre- and post-operative procedures are considered part of any associated covered service. Benefit will be limited to the Covered Amount for the covered service.
- f) Local anesthesia is considered part of any associated covered service. Benefit will be limited to the Covered Amount for the covered service.
- g) The Covered Amount for a covered service Started but not Completed will be limited to the amount determined by Delta Dental.
- h) Allowance for an assistant surgeon, when determined by Delta Dental to be a covered service, will not exceed 20% of the surgeon's fee for the same covered service.
- i) Services related to another category of covered services may be covered at the same percentage as the related category of covered services.
- j) Covered services will not be compensated when delivered in response to injuries or conditions that are covered under worker's compensation or employer's liability laws.
- k) Covered services will not be compensated when provided by any federal or state agency.
- l) Covered services provided without cost by any city, county, or other political subdivision will not be compensated.
- m) Covered services for which the person would not have to pay if not insured—such as those delivered to a family member or employee of the Provider—will not be compensated.
- n) Any covered service Started when the person was not covered under this contract will not be compensated. This includes any service Started during an applicable waiting period.
- o) Any covered service provided primarily for cosmetic purposes will not be compensated, except where an Alternate Benefit will be provided as set forth in this contract.
- p) Porcelain or resin fused to metal onlays or inlays after the first molar are considered cosmetic. The allowance will be limited to the least costly covered service that meets accepted standards of dental care as determined by Delta Dental, and the patient is responsible for the remainder of the Provider's approved fee.
- q) Covered services to treat tooth structure lost from wear, erosion, attrition, abrasion, or abfraction will not be compensated.
- r) Covered services will not be compensated when delivered as a result of improper alignment, occlusion, or contour.

- s) Covered services related to periodontal stabilization of teeth (splinting) will not be compensated.
- t) Covered services will not be compensated when the patient's oral health will not improve due to an underlying condition.
- u) Covered services will not be compensated when provided in anticipation of future need (**except** covered preventive services).
- v) Covered services for grafting procedures will not be compensated when completed in the mouth where teeth are not present.
- w) Covered services for grafts of tissues from outside the mouth into the mouth will not be compensated.
- x) Covered services not performed in accordance with Colorado state law will not be compensated.
- y) Covered services will not be compensated if administered by any person other than a person licensed to perform them.
- z) Covered services to treat any condition, other than an oral or dental disease, abnormality, or condition will not be compensated.
- aa) Covered services to replace lost, stolen, or damaged items will not be compensated.
- bb) Covered services to repair items altered by someone other than a Provider will not be compensated.
- cc) Covered services for which charges would not have been made but for this coverage, except for services as provided under Medicaid, will not be compensated.
- dd) Covered services will not be compensated when delivered as a result of self-injury.
- ee) Covered Services for any grafting procedure when done in the same site as a tooth extraction, apicoectomy, or hemisection (except bone grafting specific to implant placement if noted in covered services) will not be compensated.
- ff) Covered Services for bone graft, biologic materials, tissue regeneration with periradicular surgery and any related services will not be compensated.
- gg) Covered services provided for treatment of teeth retained in relation to an overdenture will not be compensated.
- hh) Any prosthodontic service provided within 60 months of special restorative services involving the same teeth will not be compensated.
- ii) Any special restorative service provided within 60 months of fixed prosthodontic services involving the same teeth will not be compensated.
- jj) Fixed and removable prosthodontic appliances (bridges and partials) will not be compensated in the same arch except when the fixed denture (bridge) replaces front teeth.

EXCLUSIONS

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

ARTICLE V. MEMBER PAYMENT RESPONSIBILITY

To receive any benefits under This Plan, a Member must pay Deductibles and Coinsurance. Members will also be responsible for paying amounts above the annual maximum, Service-related maximums, and all charges for Services not covered under This Plan. Members may also be responsible for some part of the premium as determined by the Group.

ARTICLE VI. CLAIMS PROCEDURE (How to File a Claim)

- 6.01 PAYMENT OF CLAIMS.** Covered Services will not include, and payment will not be made for claims for dental Services not listed in this Contract and any appendix, amendment, or rider. Claims submitted to Delta Dental must use terms of the American Dental Association Current Dental Terminology (Code on Dental Procedures and Nomenclature).
- 6.02 PRE-TREATMENT ESTIMATE.** Before beginning a course of treatment, a description of that course of treatment may be submitted to Delta Dental. Delta Dental will provide an estimate of the benefits for the planned course of treatment. Delta Dental does not require pre-treatment estimates. However, Delta Dental offers this Service in order to allow for treatment planning.
- 6.03 CLAIMS FROM NON-PARTICIPATING PROVIDERS.** Payment for Completed Covered Services from a Non-Participating Provider will be based on the Non-Participating Maximum Plan Allowance. The Member will be responsible for the difference between any Plan reimbursement and the full cost of Service.
- 6.04 CLAIMS FROM PARTICIPATING PROVIDERS.** Payment for Completed Covered Services provided by a Participating Provider will be made directly to the Provider. For Covered Services, Members do not have to pay any amount above what Delta Dental allows. For PPO Participating Providers, the amount Delta Dental allows is set forth in the PPO Schedule of Allowances. For Premier Participating Providers, the amount Delta Dental allows is the Premier Maximum Plan Allowance. If the Participating Provider charges more for a Service than Delta Dental allows, that amount is not chargeable to the patient.
- 6.05 TIME FRAME FOR SUBMISSION OF CLAIM.** Delta Dental will not pay claims submitted more than 12 months after the date the Service is Completed. If a Participating Provider failed to submit a claim within this time, the Member will not be liable for the amount that Delta Dental would have paid.
- 6.06 COORDINATION OF BENEFITS.** This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order-of-benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

6.06.01 DEFINITIONS. Coordination of Benefits means taking into account other Plans when paying Benefits.

Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering a Member. When a Plan provides benefits in the form of Services, the reasonable cash value of each Service will be considered an Allowable Expense and a Benefit paid. An expense that is not covered by any Plan covering the Member is not an Allowable Expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

- (1) If a Member is covered by two or more Plans that compute their Benefit payments on the basis of a relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
- (2) If a Member is covered by two or more Plans that provide Benefits or Services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
- (3) If a Member is covered by one Plan that calculates its Benefits or Services on the basis of a relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its Benefits or Services on the basis of negotiated fees, the primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the Benefit or Service for a specific negotiated fee or payment amount that is different than the primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
- (4) The amount of any benefit reduction by the Primary Plan because a covered Member has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions, and preferred Provider arrangements.

Claim Determination Period is usually a calendar year, but a Plan may use some other period of time that fits the coverage of the group contract. A person is covered by a Plan during a portion of a Claim Determination Period if that person's coverage starts or ends during the Claim Determination Period. However, it does not include any part of a year during which a person has no coverage under This Plan or before the date this COB provision or a similar provision takes effect.

Closed-panel Plan is a Plan that provides health benefits to covered persons primarily in the form of Services through a panel of Providers that have contracted with either directly or indirectly or are employed by the Plan and that limits or excludes Benefits for Services.

Custodial Parent means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order-of-benefit Determination Rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has coverage under more than one Plan.

When This Plan is Primary, its benefits are determined before those of any other Plan and without considering any other Plan's Benefits. When This Plan is Secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits, so that all Plan Benefits do not exceed 100% of the total Allowable Expense.

Plan means a Plan that provides Benefits or Services for dental care on a group 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 means coverage that must pay first. The Primary Plan must pay up to its full liability.

Secondary Coverage means coverage that pays a claim after the Primary Plan pays.

This Plan means, in a COB provision, the part of the contract providing the health care Benefits to which the COB provision applies, and which may be reduced because of the Benefits of other Plans. Any other part of the contract providing health care Benefits is separate from This Plan. A contract may apply one COB provision to certain Benefits, such as dental Benefits, coordinating only with similar Benefits, and may apply another COB provision to coordinate other Benefits.

6.06.02 WHEN COORDINATION OF BENEFITS APPLIES.

Coordination of Benefits applies when a Member is covered under more than one Plan. The Benefits of This Plan will be coordinated with the other Plan(s).

6.06.03 RULES FOR COORDINATION OF BENEFITS.

The rules for the order of payment are shown below.

- a) The Primary Plan pays or provides its Benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- b) (1) Except as provided in paragraph (2), a Plan that does not contain a Coordination of Benefits provision that is consistent with these rules is always primary unless the provisions of both Plans state that the complying Plan is primary.

(2) Coverage that is obtained by virtue of membership in a group and designed to supplement part of the basic package of Benefits may provide supplementary coverage that shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed-panel Plan to provide out-of-network benefits.

- c) A Plan may consider the Benefits paid or provided by another Plan in determining its Benefits only when it is secondary to that other Plan.
- d) Each Plan determines its order of benefits using the first of the following rules that apply:
 - (1) Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent, for example as an employee, Member, Subscriber, or retiree is the Primary Plan, and the plan that covers the person as a Dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (e.g., a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, Member, Subscriber, or retiree is the Secondary Plan and the other Plan is the Primary Plan.
 - (2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan, the order of benefits is determined as follows:
 - (A) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (i) The Plan of the parent whose birthday (month and day) falls earlier in the calendar year is the Primary Plan; or
 - (ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
 - (B) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - (i) If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Plan years commencing after the Plan is given notice of the court decree;
 - (ii) If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
 - (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

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

(C) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, Member, Subscriber, or retiree or covering the person as a Dependent of an employee, Member, Subscriber, or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, Member, policyholder, Subscriber, or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan.

ARTICLE VII. GENERAL POLICY PROVISIONS

7.01 RIGHT TO INFORMATION AND RECORDS. Delta Dental may receive records related to the treatment of a Member from any Provider. Delta Dental may require a Member to be examined by a dental consultant retained by Delta Dental. Delta Dental will maintain records in a confidential manner in accordance with federal and state law.

7.02 CLAIMS REIMBURSEMENT

Weekly: Payments are drafted every Wednesday for weekly claims and final claims are drafted on the first business day of the following month. One exception is the last week of the month Delta Dental will bill on the last day of the month instead of Tuesday and draft on the first business day of the next month. Monthly administrative fees will be drafted on the 15th of the following month.

Monthly: Payments are drafted on the 15th of the following month for monthly claims and admin fees. Delta Dental will notify the Group of the total amount of Providers' statements paid or otherwise discharged by Delta Dental for services rendered. Using one of the options described below, a prompt transfer of funds is made to Delta Dental to cover such disbursements as they become due and payable upon receipt of said notification.

a) Automated Clearing House Transfer (ACH Transfer)

Once the Group is notified of the total claims paid, Delta Dental has authorization from the Group to initiate an electronic transfer of funds from the Group's account to cover the total claims paid by Delta Dental. The ACH Transfer will occur 2 business days following the Group's receipt of the total claims paid by Delta Dental.

b) Wire Transfer

Once the Group is notified of the total claims paid, the Group initiates the electronic transfer of funds from their account to cover the total claims paid by Delta Dental. The electronic fund transfer must be completed within 5 business days of the Group receiving the invoice.

7.03 MONTHLY SERVICE FEE. The Monthly Service Fee for each Subscriber is as noted on the Declaration Page. The Group agrees to remit to Delta Dental during the Contract Term a monthly Service Fee for each subscriber. This is due and payable on the 15th day of each month for the previous month's Service fee.

7.04 SERVICE FEE AND CLAIMS REIMBURSEMENT AT TERMINATION. In the event this Contract terminates for any reason, the Applicant will be liable for all Service Fees due but unpaid, as well as Claims Reimbursement for all claims for Services incurred by any Member prior to the effective date of termination.

7.05 CHANGE OF SERVICE FEE. In the absence of an amendment mutually agreed upon between Applicant and Delta, no change in the Service Fee will be made during a Contract Year.

7.06 CLERICAL ERRORS. Clerical errors or delays in maintaining or exchanging data relative to coverage will not validate or invalidate coverage that would otherwise be in force. Upon discovery of such errors or delays, an adjustment of charges will be made.

7.07 GRACE PERIOD.

- **Service Fee.** The Contract has a Grace Period of 15 days after the due date of the Service Fee bill.
- **Claims Reimbursement. Weekly:** Payments are drafted every Wednesday for weekly claims and final claims will be drafted on the first business day of the following month. One exception is the last week of the month Delta Dental will bill on the last day of the month instead of Tuesday and draft on the first business day of the next month. Monthly administrative fees will be drafted on the 15th of the following month.

Monthly: Payments are drafted on the 15th of the following month for monthly claims and admin fees.

The coverage remains in force during this Grace Period unless terminated by the Group. If either the Service Fee or Claims Reimbursement are not paid by the end of the Grace Period, the Contract will be placed on a hold status, where no claims will be paid and no eligibility will be guaranteed. If the Group does not pay after this Grace period, they may be terminated as of the last date of the earliest Grace Period at the discretion of Delta Dental. Service Fees and Claim Reimbursement are due through the last day of the Grace Period, including the Grace Period.

7.08 TIMELY NOTICE. Delta Dental must be informed when any Subscriber is no longer eligible. Failure to provide timely notice does not continue a Subscriber's coverage past the time it would otherwise have ended. Group shall be liable for any payments made by Delta Dental in reliance upon faulty eligibility information supplied and/or not corrected by Group.

7.09 EXTENDED COVERAGE. Delta Dental Benefits will end if this Contract is terminated or if a person's coverage is cancelled. Delta Dental will cover no further Services except as described below.

If a Covered Service Started before coverage ends, but the Covered Service is Completed after it ends, Delta Dental will pay Benefits for the Covered Service as follows:

- Benefits will be paid in the amount that would have been paid and subject to the same terms as would have applied if the person's coverage were still in effect.
- Benefits will be paid only if the Covered Service is Completed within 60 days after the date the person's coverage ended.
- Extended Coverage benefits are not applied to orthodontic Services.

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

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

- 7.11 NOTICES.** Any notice under this Contract will be valid if given by either the Applicant or Delta Dental to the other. In the case of the Applicant, notice may be given to a designated agent. The notice will be effective upon the date of mailing.
- 7.12 NOTICES TO SUBSCRIBERS.** Notice to a Subscriber will be in writing and sent by regular US mail to the current address in Delta Dental's records. If agreed to by Delta Dental and the Subscriber, notices may be sent via email.
- 7.13 LEGAL ACTION.** No action at law or in equity may be filed in order to recover on this Contract prior to the expiration of 60 days after final notice of claim has been filed in accordance with the requirements of this Contract.
- 7.14 REPRESENTATIONS.** All statements made by the Group or by an individual will be deemed representations and not warranties.
- 7.15 ENTIRE CONTRACT; AMENDMENTS.** This Contract is the complete agreement between Delta Dental and the Group. This Contract may not be orally amended or changed. This Contract may at any time be amended and changed by written agreement between Delta Dental and the Group. Any such amendment will be binding on all Members regardless of the date their coverage became effective or the date treatment was Started.
- 7.16 RESERVATION OF RIGHTS.** Delta Dental reserves all rights not expressly granted to either party in this Contract. Delta Dental may change or end the plan if required due to changes in federal or state laws and/or regulations governing healthcare benefits, the requirements of the Internal Revenue Code or ERISA, the provisions of a contract, or any other reason.
- 7.17 GROUP'S ACCESS TO RECORDS.** Delta Dental agrees that Group or its designated representative may access all files and records pertinent to the Group in accordance with federal and state laws. The group must give 14 days' written advance notice.
- 7.18 SETTLEMENT OF DISPUTES.** Any dispute between Delta Dental, a Participating Provider, and Member, or any combination of these, must be settled by arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association. Except for ERISA covered claims, disputes include adverse claim decisions not settled by the appeals process. Judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. Arbitration may be initiated by any party to a dispute by giving notice to each party, by filing two copies of such notice with the American Arbitration Association, and by complying with other applicable provisions of the association's rule.
- 7.19 SUBSCRIBER BENEFIT BOOKLET.** Delta Dental will give a Subscriber Benefit Booklet to the Group. The Group will make the booklet available to each Subscriber. If an amendment to this Contract will materially affect the Benefits in the booklet, we will give a revised Subscriber Benefit Booklet or inserts showing the change to the Group.
- 7.20 PHYSICAL EXAMINATION.** Delta Dental, at its own expense, may examine an individual for whom a claim or request for pre-estimation of Benefits is pending under this Contract.
- 7.21 GENDER.** The use of the singular will include the plural and the plural the singular. Use of any gender will include all genders.

- 7.22 HIPAA PRIVACY & SECURITY.** Delta Dental complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security regulations.
- 7.23 AGREEMENT WITH STATE LAW.** Any requirement in this Contract that on the group's effective date is in conflict with the laws of the state in which any Member lives is hereby changed to the minimum requirement of such laws.
- 7.24 NON-DISCRIMINATION.** Delta Dental does not use individual health factors to determine benefits or premium rates. Health factors include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

ARTICLE VIII. TERMINATION/NONRENEWAL/CONTINUATION

- 8.01 RENEWAL.** The Contract will renew for one-year periods unless either party elects not to renew by giving the other party written notice. Notice must be received at least 60 days before the end of the current Contract Year. If there are changes to the rates or other terms of this Contract effective on an Anniversary Date, Delta Dental will provide notice of the proposed changes with the notice of renewal.
- 8.02 TERMINATION.** This Contract may be terminated as follows:
- a) By either the Group or Delta Dental at the end of the initial Contract or at the end of any Contract Year if the required notice of non-renewal is given.
 - b) In the event any Service Fee due as stated in Article VII of this Contract is not paid within 20 days of the due date, Delta Dental may give notice that payment is due, and if such payment is not received by the last day of the Grace Period, as referenced in Article VII, Section 7.07, Delta Dental may terminate all further obligations.
 - c) In the event any Claims Reimbursement due as stated in Article VII of this Contract is not paid within 10 calendar days of the due date, Delta Dental may give notice that payment is due, and if such payment is not received by the last day of the Grace Period, as referenced in Article VII, Section 7.07, Delta Dental may terminate all further obligations.
 - d) By election of the Group if Delta Dental defaults in providing the Benefits under the Contract and such default is not corrected within 60 days of notice of such default.
 - e) By election of Delta Dental in the event enrollment of Subscribers changes by 10% or more from the minimum enrollment requirements included on Delta Dental's proposal. Delta Dental may, at its option, terminate or propose to the Group alternative adjustment in rates, Benefits, or copayments. Within 30 days, the Group will select an alternative by written notice to Delta Dental. If an alternative is not selected, Delta Dental may terminate this Contract.
 - f) Upon written notification by the Group of its intention to terminate this Contract as of any date other than the end of the Contract Term. The termination date will be the last day of the month during which Delta Dental received the Group's written notification of intent to terminate.
 - g) By election of Delta Dental in the event of fraud or misrepresentation by the Applicant, or with respect to coverage of a Subscriber, fraud or misrepresentation by the Subscriber or such person's representative.

In the event this Agreement terminates as stated, the Group will remain liable to Delta Dental for the full amount of the Providers' statements paid or otherwise discharged by Delta Dental for services rendered and incurred under this Contract prior to the termination date. In addition, the Group will be and remain liable to Delta Dental for a period of 12 months following the termination date for the full amount of Provider's statements paid or otherwise discharged by Delta Dental for services rendered according to ARTICLE VI, CLAIMS PROCEDURE, 6.03 and 6.04.

8.03 PROCEDURES ON TERMINATION

- a) In the event of termination of this Agreement in accordance with the provisions of Article VIII, Section 8.02, no Subscriber will, on or after the date on which the termination takes effect, be entitled to any further benefit payments hereunder and Group will indemnify and hold Delta Dental harmless with respect to any claims by or with respect to Subscribers for further benefit payments hereunder without regard to the date on which the dental claims were incurred.

However, Delta Dental will have the right to process Providers' statements for payment where each of the following terms are met, provided that any Claims Reimbursement and Service Fees owed Delta Dental have been paid:

1. the Provider's statement is first received by Delta Dental within 12 months of the termination date of this Agreement according to ARTICLE VI, CLAIMS PROCEDURE, 6.03 and 6.04;
 2. the date of service reported on the Provider's statement was within 12 months of the date the claim was first received by Delta;
 3. the date of service reported on the Provider's statement was no later than the termination date of this Agreement.
- b) In the event of termination by Delta Dental, all Benefits will terminate and Delta Dental will be released from all further obligations of this Agreement, effective on the last day of the month in which written notice of termination is given; provided, however, that Delta Dental will make payments for dental services for Extended Benefits. Applicant will remain liable to Delta Dental for:
1. the unpaid payments applicable for the period this Agreement was in effect prior to termination; and
 2. the full amount of all Provider's statements paid or otherwise discharged by Delta Dental after the termination date but incurred during the full Term of this Contract.
 3. In the event of termination of this Agreement for any cause, Delta Dental will not be required to pay for services provided beyond such termination date, except for the completion of single procedures started while this Agreement was in effect, which are otherwise Benefits under the terms of this Agreement, provided that any Claims Reimbursement and Service Fees owed Delta Dental have been paid.

8.04 If on termination of this Contract for any cause Group has not paid Service Fee and/or Claims Reimbursement to Delta Dental applicable to a period of time up to and including the termination date Group will, within 30 days after termination, remit such to Delta Dental.

8.05 COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) Generally applies to groups with 20 or more employees.

Under COBRA, Members who have a qualifying event may be able to continue coverage for a period of time. The Benefits will be the same as those of active Subscribers. The Member must pay the Premium, which cannot exceed 102% of the cost for an active employee with the same plan. Qualifying events govern if a person may elect COBRA and the length of coverage. The employer or Group must administer COBRA according to federal requirements.

COBRA continuation coverage will end 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 for which Premium has been paid;
- d) The day the person becomes entitled to Medicare;
- e) The day the person is eligible for coverage under another Group Plan.

8.06 CONTINUED HEALTH COVERAGE (Colorado State Continuation) Applies to Groups not subject to COBRA.

Members covered under this Contract, or a similar Contract it replaces, for at least six months may be able to continue coverage for up to 18 months under State Continuation. Their Premium and Benefits will be the same as those for active Subscribers, except that the Member will be responsible for the Premium. The employer or Group must administer State Continuation according to state law.

State Continuation coverage is effective upon loss of coverage. Within 60 days of the loss, the Group must send enrollment information and Premium to Delta Dental for the Member's benefits to continue.

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

- a) The last day of the month after 18 months of continued coverage;
- b) The day the Contract terminates;
- c) The last day of the month that Premium is paid;
- d) The day the person becomes entitled to Medicare;
- e) The day the person is eligible for coverage under another Group Plan; or
- f) In the case of a Dependent child, the day they no longer meet the definition of Dependent.

ARTICLE IX APPEALS AND COMPLAINTS

9.01 APPEALS of ADVERSE DETERMINATIONS

A. Internal Appeal Process — First-level Appeals

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

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

Additional information should be submitted in support of the appeal.

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

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

B. Internal Appeal Process — Second-level Appeals (not available for self-funded Groups)

If a denial is upheld at the first level, a Member may request a second-level appeal. The request must be received within 30 days of the First-level appeal decision. It must be submitted to the address noted in 9.01A. Additional information may be submitted. Second-level appeals will be reviewed by an impartial Provider with the appropriate expertise. The reviewer will not have been involved in the first appeal. The Member, or a designated representative, may request to appear before the reviewer in person or may present by conference call.

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

C. Internal Appeal Process — Expedited Appeals

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

Expedited review decisions will be issued within 72 hours.

D. Independent External Review (not available for Self-Funded or Federal Groups)
Where Delta Dental makes an Adverse Determination and the Member exhausts the internal appeals process, the Member has the right to request an external review. Delta Dental will notify the Member of the right, if any, to request an external review after the First Level appeal.

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

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

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

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

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

ARTICLE X. INFORMATION ON POLICY AND RATE CHANGES

- 10.01 CONTRACT CHANGES UPON RENEWAL.** The terms of this policy, including the rates payable by the Group, may be amended upon its renewal pursuant to the terms set forth in Section 8.01.
- 10.02 ALL OTHER CONTRACT CHANGES.** Except as set forth in Sections 7.17, 7.18 and 8.01, no agent or employee of Delta Dental may change the Contract or waive any of its provisions. No change in the Contract will be valid unless approved in writing by an authorized Delta Dental employee.

ARTICLE XI. DEFINITIONS

The terms below apply to this Contract:

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

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

11.03 APPLICANT means the Group or employer wishing to provide dental benefits.

11.04 BENEFITS mean the Services described in this Contract in the Benefits Rider, BENEFITS, LIMITATIONS, and EXCLUSIONS.

11.05 CLAIMS REIMBURSEMENT means the amount of money the Group must pay Delta Dental for the total amount of Providers' statements paid or otherwise discharged by Delta Dental for services rendered for all Subscribers.

11.06 COINSURANCE means the percent of a Covered Amount that the member will pay. The Coinsurance for each type of Covered Service is determinable by subtracting the "Plan Pays" amount on the Declarations Page from 100 percent. The Coinsurance that applies to a Subscriber may vary by type of dental Service.

11.07 COMPLETED means:

- For root canal therapy, the date the canals are permanently filled.
- For fixed bridges (fixed partial dentures), crowns, inlays, onlays, and other laboratory prepared restorations: The date the restoration is cemented in place.
- For dentures and partial dentures (removable partial dentures): The date that the final appliance is first inserted in the mouth.
- For all other Services: The date the procedure is Started.

A Benefit is only payable once Completed.

11.08 The **CONTRACT ANNIVERSARY DATE** or **ANNIVERSARY DATE** is noted on the Declaration Page of this Contract. The Anniversary Date is the first day of each Contract Year following the initial Contract Year.

11.09 CONTRACT means this agreement between Delta Dental and the Applicant. It includes attached appendices, exhibits, and riders, if any. This Contract is the whole agreement between the parties.

11.10 CONTRACT TERM means the time from the Group's Effective Date of the Contract until it is terminated.

11.11 CONTRACT YEAR is the 365 days beginning on the Group's Effective Date of this Contract and each year after unless the contract is terminated. The contract year is 366 days in a leap year.

11.12 COVERED AMOUNT means:

- For PPO Providers, the lesser of the amount set forth in the PPO Schedule of Allowances or the fee actually charged.
- For Premier Participating Providers, the lesser of the Premier Maximum Plan Allowance or the fee actually charged.
- For all other Providers, the lesser of the Non-Participating Maximum Plan Allowance or the fee actually charged.

11.13 COVERED SERVICES mean the Services described in this Contract or attachments, subject to the limitations and exclusions noted.

11.14 DEDUCTIBLE means the amount the Member must pay before Delta Dental pays. The Deductible is shown on the Declarations Page. If there is a limit to the deductible that a family must pay, that will be shown on the Declarations Page.

11.15 DEPENDENT means:

- The Subscriber's lawful spouse, including civil-union partner or domestic partner.
- Civil-union partner must:
 - ❖ Be at least 18 years old.
 - ❖ Not be a partner in another civil union.
 - ❖ Not be married to another person.
 - ❖ Not be related to the Subscriber.
 - ❖ Have entered into a civil union based on the guidelines of Article 15 of Title 14, C.R.S. recognized pursuant to Colorado law.
- Domestic partner must meet each of the requirements listed below:
 - ❖ Be at least 18 years old and view themselves as a family.
 - ❖ Be of the same or opposite sex.
 - ❖ Not be married and may not have another partner.
 - ❖ Have lived together for at least 6 consecutive months.
 - ❖ Not be related to the Subscriber.
 - ❖ Be financially interdependent.
- A child under the Dependent age limit shown on the Declaration Page.
- A child who reaches the Dependent Age Limit stated on the Declarations Page and is incapable of self-support because of physical or mental disabilities that began before reaching the Dependent age limit and is dependent on the Subscriber. Delta Dental may annually request proof of such disability and dependency. Failure to submit such proof will terminate coverage.

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

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

Persons in active military service are not eligible Dependents.

11.16 GROUP EFFECTIVE DATE is the date coverage begins for the group.

11.17 MEMBER EFFECTIVE DATE is the date coverage begins for the member.

11.18 ELIGIBLE CLASS is a group of Subscribers who are allowed to enroll under the Contract.

11.19 ELIGIBILITY WAITING PERIOD refers to active Subscribers who have met the minimum requirements necessary to be eligible for enrollment through the employer's Plan and who will become eligible with Delta Dental on the date specified by the employer. Delta Dental does not maintain any eligibility waiting periods that are set forth by the employer.

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

11.21 EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES means those Services not generally accepted in the dental community as being safe and effective, as defined by Delta Dental.

11.22 GROUP means the Applicant or employer contracting for dental Benefits.

11.23 MAXIMUM PLAN ALLOWANCE means the most that a Provider is allowed to charge for a procedure. Delta Dental reviews the limits twice a year. Delta Dental reserves the right to increase or decrease fees for any procedure in its sole and absolute discretion.

11.24 MEMBER means any person—Subscriber or Dependent—eligible and enrolled for coverage under This Plan.

11.25 NECESSARY means a Service that Delta Dental decides, using accepted standards of dental care and Delta Dental's processing policies, is needed and fitting for treatment of the Member's dental condition.

11.26 NON-PARTICIPATING PROVIDER means a Provider who does not contract with Delta Dental.

11.27 OPEN ENROLLMENT means a period prior to the Anniversary Date when eligible Subscribers and their Dependents may enroll. They may also change from one Plan to another if the Contract permits them to do so. Coverage is effective on the Applicant's Anniversary Date.

11.28 PARTICIPATING PROVIDER means a Provider who contracts with Delta Dental.

- **Premier Participating Provider** means a Provider who has executed a Premier Participating Provider Agreement with Delta Dental.
- **PPO Participating Provider** means a Provider who has executed a PPO Provider Agreement with Delta Dental.

11.29 PREMIUM means the amount of money paid for each Subscriber to buy the Benefits provided in this Contract.

11.30 PRE-TREATMENT ESTIMATE is a review of a Provider's plan of care to determine what will be covered under this Contract.

11.31 PROVIDER means a person licensed to provide dental Services.

11.32 SERVICE means a procedure or supply provided by a Provider.

11.33 SERVICE FEE means the amount of money paid to Delta Dental for each Subscriber to purchase the Administrative Services provided by this Contract, as provided in Article VII.

11.34 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 performed.
- For all other Services: The date the Service is performed.

11.35 SUBSCRIBER means:

- An enrolled Employee for whom the monthly Premium is paid.
- A person who elects continued coverage and for whom the monthly Premium is paid.