DELTA DENTAL®

Dental Benefit Handbook

for New Mexico Retiree Health Care Authority

Comprehensive Plan

Delta Dental of New Mexico

www.deltadentalnm.com

This page is intentionally left blank.

Dental Benefit Handbook

Delta Dental of New Mexico

NMRHCA Comprehensive Plan

Thank you for choosing Delta Dental of New Mexico for your fully insured dental Benefits. We recommend reviewing this Dental Benefit Handbook for general information about your Benefits, including topics such as eligibility, how to use your Benefits, and how we define Benefits and their accompanying limitations and exclusions. Please refer to your Summary of Dental Plan Benefits for specific information about your Plan and available Provider network(s).

Benefits are provided under a Professional Services Contract ("Contract") entered into between the New Mexico Retiree Health Care Authority (NMRHCA) ("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 are 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 NMRHCA.

This Dental Benefit Handbook, along with the Summary of Dental Plan Benefits, describes important Plan provisions. To the extent that anything set forth in this Handbook conflicts with your Summary of Dental Plan Benefits, your Summary of Dental Plan Benefits will control. Any modification to this Plan will apply to all Enrollees covered by this Plan at the time of such changes.

To obtain copies of Plan documents, including the Dental Benefit Handbook and the Summary of Dental Plan Benefits, please contact Delta Dental Customer Service by calling (877) 395-9420 or sending an email to customerservice@deltadentalnm.com. You can also request these documents from your organization's Human Resources or Benefits Manager.

You can access lists of Delta Dental Participating Providers by using the Provider search feature on www.deltadentalnm.com.

Please take time now to become familiar with your dental coverage. For answers to questions about Benefits, please call:

Delta Dental of New Mexico
Customer Service Department
(505) 855-7111 or toll-free (877) 395-9420

Oral health is an important part of your overall wellness. Delta Dental plans are designed to promote regular dental visits. Take advantage of your Benefits by calling a Delta Dental Participating Provider today for an appointment.

Table of Contents

I. Eligibility and Enrollment 1

II. Accessing Your Benefits 2

III. Benefits, Limitations, and Exclusions 7

IV. Coordination of Benefits 19

V. Claims Appeal 21

VI. Termination of Coverage 24

VII. Continuation of Coverage 25

VIII. ERISA 25

IX. Notice of Privacy Practices 25

X. General Conditions 26

XI. Definitions 28

I. Eligibility and Enrollment

A. Determining Eligibility

1. Eligible individual retirees and dependents of those retirees, as determined and administered by NMRHCA, per Contract with Delta Dental, may enroll. Dental Plan eligibility requires that a dependent Spouse or child of a retiree enroll in the same Plan option as the retiree. An eligible retired Spouse may enroll for different Plan options only when enrolling separately.

2. Once enrolled in a dental Plan offered by NMRHCA, an Enrolled Retiree may drop coverage at any time. However, once an Enrolled Retiree has cancelled coverage, he or she may not re-enroll for four years. The four-year waiting period does not apply to an involuntary loss of coverage.

3. NMRHCA is responsible for submitting monthly Premium to Delta Dental on behalf of all Enrollees. Premium may include contributions by Enrollees as determined by NMRHCA.

B. Effective Dates of Coverage

1. Coverage effective dates are determined by NMRHCA subject to its Contract with Delta Dental. Coverage for an Enrollee becomes effective on the first day of the month for which Premium applies.

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

II. Accessing Your Benefits

This section describes basic information about selecting a Provider and how to access your Benefits. Please refer to your Summary of Dental Plan Benefits for specific information about the network(s) available under your Plan and the effect of your Provider selection. If you have additional questions regarding how your Plan works, please call Delta Dental Customer Service at (505) 855-7111 or toll-free (877) 395-9420.

A. General Information About Selecting a Provider

1. Your Summary of Dental Plan Benefits contains specific information about your dental Plan's network(s). You will have the lowest out-of-pocket costs when you select a Provider who participates in the network specified at the top of your Summary of Dental Plan Benefits.
2. You can search for Participating Providers on **www.deltadentalnm.com**.
3. Delta Dental does not require that you pre-select a Provider and does not guarantee that a particular Provider will be available.
4. Each Enrolled Person in your family may choose a different Provider.
5. You are responsible for the full payment for any non-covered services.

B. Accessing Benefits

To use this Plan, follow these steps:

1. Read this Handbook and the Summary of Dental Plan Benefits carefully to become familiar with your Benefits, network(s), Delta Dental's method of payment, and the provisions of this Plan.
2. 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 questions regarding this Plan, the dental office may contact the Delta Dental Customer 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 Delta Dental Participating Providers will file the claim directly with Delta Dental. Non-Participating Providers may require patients to file their own claims. Claims for Benefits must be submitted to Delta Dental in writing within twelve (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 twelve (12) months. Upon review, Delta Dental will make a final determination.
4. Enrolled individuals are responsible for filing claims for services received from a Non-Participating Provider, including Providers 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 the name of the clinic and Provider, tooth number or area of the oral cavity (if applicable), a description of each individual service, a date of service, a fee for each individual service, and a signature by the Provider. Upon review of any out-of-country claim,

Delta Dental may respond to you with a letter requiring your signature acknowledging you received the specified dental services.

For out-of-country claims, Delta Dental requires an itemized receipt indicating the country's currency. For Mexican claims, the receipt must be numbered, include a tax stamp as mandated by Mexican legislation, and show the paid amount in pesos (not U.S. dollars). Compliance is required by Mexico's Tax Authorities.

If the services performed outside of the United States are for extractions, crowns, bridges, dentures, or partial dentures, a radiographic image 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, filing a claim with Delta Dental, and paying the Provider 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 Blvd. NE STE 600, Albuquerque, New Mexico, 87110. The Delta Dental Customer Service Department is available Monday through Friday, 8:00 a.m. – 4:30 p.m. Mountain Time, at (505) 855-7111 or toll-free (877) 395-9420.

6. Within thirty (30) days of receiving a valid claim, Delta Dental will make available 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 made available to the Enrolled Retiree, or other appropriate beneficiary, and to the treating Provider if a Delta Dental Participating Provider. The thirty (30) day period for claim determination may be extended by an additional fifteen (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 thirty (30) day period.

   In the event a Group does not pay its monthly Premium, all claims for that Group will be placed on hold. If a claim is on hold for more than thirty (30) days, it may be denied, in which case the Enrollee becomes responsible for any outstanding fees owed to his or her dental Provider.

7. If a claim for Benefits is reduced or denied, the Explanation of Benefits will state the reason for the Adverse Benefit 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."

8. You may appoint an Authorized Representative to make contact with Delta Dental on your behalf with respect to any Benefit claim you file or any review of a denied claim you wish to pursue. To download the form to designate your Representative, visit **www.deltadentalnm.com**, or request a form by calling the Customer Service Department at (505) 855-7111 or toll-free (877) 395-9420, or mailing a letter to 2500 Louisiana Blvd. NE STE 600, Albuquerque, New Mexico, 87110. Once you have appointed an Authorized

Representative, Delta Dental will communicate directly with your Representative.

9. For questions and assistance regarding your coverage, you may contact NMRHCA or call Delta Dental's Customer Service Department at (505) 855-7111 or toll-free (877) 395-9420. You may also write to Delta Dental's Customer Service Department at 2500 Louisiana Blvd. NE STE 600, Albuquerque, New Mexico, 87110. When writing to Delta Dental, please include your name, that you are an Enrollee of NMRHCA, your member ID number, and your daytime telephone number. If you need the assistance of the government agency that regulates insurance, or have a complaint you have been unable to resolve, you may contact the Office of Superintendent of Insurance.

10. Pre-Treatment Estimates – A Pre-Treatment Estimate of Benefits provides both the patient and the Provider 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, allowing you to know what services may be covered before your Provider provides them. A Pre-Treatment Estimate is not required to receive payment, unless specified in the Summary of Dental Plan Benefits. Your Provider submits the proposed dental treatment to Delta Dental in advance of providing the treatment. You and your Provider should review your Pre-Treatment Estimate before treatment. Once treatment is complete, the dental office will submit a claim to Delta Dental for payment.

    a. A Pre-Treatment Estimate is for informational purposes only and is not required before you receive dental care, unless specified in the Summary of Dental Plan Benefits. It is not a prerequisite or condition for approval of future dental Benefits payment. You will receive the same Benefits under this Plan whether or not a Pre-Treatment Estimate is requested. The Benefits estimate provided on a Pre-Treatment Estimate notice is based on Benefits available on the date the notice is received. It is not a guarantee of future dental Benefits or payment.

    b. Availability of dental Benefits at the time your treatment is completed depends on several factors. These factors include, but are not limited to, your continued eligibility for Benefits, your available annual or lifetime Maximum Benefit Amount, Coordination of Benefits, the status of your Provider, this Plan's limitations and any other provisions, together with any additional information or changes to your dental treatment. A request for a Pre-Treatment Estimate is not a claim for Benefits or a preauthorization, precertification, or other reservation of future Benefits.

11. If an Enrollee receives emergency care for services specified in your dental Plan and cannot reasonably reach a Participating Provider (as outlined in the Summary of Dental Plan Benefits), the emergency care rendered during the course of the emergency will be reimbursed as though the Enrollee had been treated by a Participating Provider.

C. Out-of-Pocket Expenses

The following out-of-pocket expenses may apply to your Plan:

1. **Deductible**
   This 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 Dental Plan Benefits.

2. **Patient Coinsurance**
   The patient Coinsurance is the percentage of Covered Services that the Enrolled Person is responsible for paying to the dental Provider. The amount of patient Coinsurance 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 Dental Plan 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 Amount applicable in the Benefit Period. The Maximum Benefit Amount is stated in the Summary of Dental Plan Benefits.

D. Clinical Review

1. All claims are subject to review by a Dental Consultant. A Dental Consultant is a licensed New Mexico Dentist who has no affiliation or connection with Delta Dental other than as an independent 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.

E. 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 Coinsurance, Deductible, and non-covered services.

2. Delta Dental will pay a New Mexico Non-Participating Provider when an 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 law or when required by the Delta Dental Plan in that state, and when an 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.

F. Right to Recover Benefits Paid by Mistake

If Delta Dental makes a Benefit payment to an 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. If Benefit payment is made under fraudulent, false, or misleading pretenses or circumstances, Delta Dental has the right to recover that payment. The right to recover a payment includes the right to deduct the amount paid from future dental Benefits for any covered family member. An explanation of the payment being recovered will be provided at the time a deduction is made.

III. Benefits, Limitations, and Exclusions

Your Benefits are outlined in your Summary of Dental Plan Benefits. Unless specified otherwise in the Summary of Dental Plan Benefits, the following 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 the Processing Policies of Delta Dental and the terms and conditions of the entire Contract. Refer to the accompanying Summary of Dental Plan Benefits for patient Coinsurance 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. To the extent that anything set forth herein conflicts with your Summary of Dental Plan Benefits, your Summary of Dental Plan Benefits will control.

A. Diagnostic and Preventive Services

Diagnostic: Procedures to aid the Provider in choosing required dental treatment (patient screenings, oral examinations, diagnostic consultations, diagnostic casts, clinical oral evaluations, and radiographic images).

Palliative: Minor, non-definitive emergency treatment to temporarily relieve pain.

Preventive: Brush biopsy and related lab tests, cleanings, application of topical fluoride, space maintainers, and sealants. Periodontal maintenance is considered to be a cleaning for Benefit frequency determination.

B. Limitations on Diagnostic and Preventive Services

1. Benefit for patient prediagnostic screenings is limited to once in a calendar year. A separate fee for patient assessment is Disallowed.
2. A caries risk assessment and documentation, with a finding of low, moderate, or high risk, is a Benefit once every thirty-six (36) months.
    a. A separate fee for a caries risk assessment is Disallowed when submitted for children under the age of three (3).
    b. A separate fee for a caries risk assessment is Disallowed within twelve (12) months of the date of service.
    c. A caries risk assessment is not a Benefit at twelve (12) to thirty-six (36) months from the date of service.
    d. A separate fee for a caries risk assessment is Disallowed when the procedure is performed in addition to any other risk assessment procedure on the same date of service by the same Provider or dental office.
3. Blood glucose level tests and HbA1c tests are not Covered Services.
4. Brush biopsies are limited to once in a twelve (12) month period. A separate fee for interpretation is Disallowed.
5. Benefits for oral examinations, including diagnostic consultations, emergency or re-evaluation exams, clinical oral evaluations, routine cleanings, and topical

fluoride treatment are limited as shown in the Summary of Dental Plan Benefits.

6. Enrollees under the age of fourteen (14) are limited to routine child cleanings. Enrollees age fourteen (14) and over will be considered adults for the purpose of determining Benefits for cleanings.

7. Full mouth debridement is only a Benefit when necessary to enable comprehensive evaluation and diagnosis on a subsequent visit and is limited to once per lifetime.

8. Delta Dental will Benefit a complete series of radiographic images as stated in the Summary of Dental Plan Benefits. A panoramic radiographic image with or without bitewing images is considered a complete series of radiographic images. Images exceeding the diagnostic equivalent of a complete series of radiographic images will be Disallowed when taken on the same date of service. Bitewing radiographic images exceeding the diagnostic equivalent of a complete series of radiographic images will be Disallowed when taken on the same date of service.

9. Emergency palliative treatment does not include Services and Supplies that exceed the minor treatment of pain. Benefit is limited to radiographic images and tests necessary to diagnose the emergency condition.

10. Services for diagnostic casts, oral/facial photographic images, 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. A separate fee for image interpretation is Disallowed.

11. Pulp tests are a Benefit per visit, not per tooth, and only for the diagnosis of emergency conditions. Fees for pulp tests are Disallowed as part of any other definitive procedure on the same day by the same Provider or dental office except for limited oral evaluation (problem focused), palliative treatment, radiographic images, and protective restorations.

12. Benefits for sealants are limited to permanent molars. Sealants are a Covered Service for Enrollees as stated in the Summary of Dental Plan Benefits.

13. A separate fee for the replacement or repair of a sealant by the same Provider or dental office is Disallowed within two (2) years of the initial placement.

14. An age limitation may apply to services related to space maintainers. Please refer to the Summary of Dental Plan Benefits for applicable age limitations.

15. Fixed bilateral space maintainers are payable once per arch per lifetime for people up to age fourteen (14).

16. Fixed unilateral, removable unilateral, and removable bilateral space maintainers are payable once per quadrant per lifetime for people up to age fourteen (14).

17. A separate fee for the removal of a space maintainer by the same Provider or dental office who placed the initial appliance is Disallowed. Removal of a

space maintainer by a different Provider or dental office is a Benefit once per appliance per lifetime.

18. Benefits for distal shoe space maintainers are payable once per area per lifetime for people up to age nine (9).
19. A separate fee for the repair or adjustment of a distal shoe space maintainer by the same Provider or dental office who placed the initial appliance is Disallowed.
20. A separate fee for the recementation, re-bond, or repair to a space maintainer by the same Provider or dental office is Disallowed within six (6) months of the original treatment. Six (6) months after the original treatment date, recementation, re-bond, or repair is a Benefit once per appliance.
21. Interim caries arresting medicament application is limited to twice per tooth per Benefit Period.
22. Preventive restorations are not a Benefit.
23. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

C. Additional Benefits for Patients with Specified Medical Conditions

Delta Dental may pay for additional Benefits for people with specified medical conditions.

1. Patients with the following medical conditions may be eligible for an additional cleaning, up to four (4) total cleanings per Benefit Period:
    a. Diabetes with periodontal disease
    b. Pregnancy with periodontal disease
    c. Renal failure/dialysis
    d. Suppressed immune system—chemotherapy/radiation treatment, HIV positive, organ transplants, and stem cell (bone marrow) transplants
    e. Head and neck radiation patients
    f. Individuals at risk for infective endocarditis
2. Qualifying heart conditions are:
    a. History of infective endocarditis
    b. Certain congenital heart defects (ex. one ventricle instead of the normal two)
    c. Individuals with artificial heart valves
    d. Heart valve defects caused by acquired conditions like rheumatic heart disease
    e. Hypertrophic cardiomyopathy (causes abnormal thickening of the heart muscle)
    f. Individuals with pulmonary shunts or conduits

g. Mitral valve prolapse (MVP) (blood leakage)

3. In addition, head and neck radiation patients may also be eligible for additional topical fluoride treatments, up to two (2) total topical fluoride treatments per Benefit Period.

4. It is important to notify your Provider of these or any other serious medical conditions and to discuss what treatment options may be right for you.

5. You must be able to submit to Delta Dental a documented diagnosis of any of the above conditions to qualify for additional procedures.

D. Restorative Services

Restorative services are amalgam, resin-based composite restorations (fillings), or 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.

E. 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 or dental office is Disallowed 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. Prefabricated resin crowns are a Benefit for primary anterior teeth only.

4. Services for metallic, porcelain/ceramic, or composite/resin inlays are limited to the Benefit for the equivalent amalgam/resin filling procedure.

5. Services for metallic, porcelain/ceramic, or composite/resin onlays are subject to clinical review, and limitations on optional services may apply.

6. Replacement of existing restorations (fillings) for any purpose other than treating active tooth decay or fracture is not covered.

7. Separate fees for more than one (1) pin per tooth or a pin performed on the same date of service as a build-up are Disallowed. A separate fee for the replacement of pin retention on the same tooth, by the same Provider or dental office, within twenty-four (24) months is Disallowed.

8. Refer to “General Limitations and Exclusions” for additional provisions that may apply.

F. Basic Services

Anesthesia: Intravenous sedation and general anesthesia.

Endodontics: The treatment of teeth with diseased or damaged nerves (for example, root canals).

Extractions: Surgical extractions. Extraction of coronal remnants of a primary tooth and extraction of an erupted tooth or exposed root are considered non-surgical extractions for Benefit determination purposes.

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

Periodontics: The treatment of diseases of the gums and supporting structures of the teeth.

G. Limitations on Basic Services

1. Evaluation for deep sedation or general anesthesia is Disallowed when billed in conjunction with an evaluation by the same Provider or dental office.
2. Intravenous (IV) sedation and general anesthesia are not Benefits for non-surgical extractions and/or patient apprehension.
3. Intravenous (IV) sedation and general anesthesia are Benefits only when administered by a licensed Provider in conjunction with specified surgical procedures, subject to clinical review and when Medically Necessary.
4. Nitrous oxide and non-intravenous conscious sedation are not covered Benefits.
5. Benefits for pulpal therapy procedures are limited to once in a twenty-four (24) month period.
6. A separate fee is Disallowed for pulp therapy procedures when performed on the same day, by the same Provider or dental office, as other surgical procedures involving the root.
7. A separate fee is Disallowed 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 or dental office.
8. A pulpotomy or pulpal debridement is a Benefit once per tooth per lifetime.
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 or dental office, within twenty-four (24) months, is considered part of the original procedure and a separate fee is Disallowed.
12. Apexification Benefits are limited to permanent teeth, once per tooth per lifetime. This procedure is Disallowed if performed by the same Provider or dental office within twenty-four (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. Scaling in the presence of generalized moderate or severe gingival inflammation is considered to be a cleaning for Benefit frequency determination.

16. Periodontal maintenance is considered to be a cleaning for Benefit frequency determination. Benefits for periodontal maintenance are limited as shown in the Summary of Dental Plan Benefits.

17. A separate fee for periodontal maintenance may be Disallowed within three (3) months of other periodontal therapy provided by the same Provider or dental office, as determined by clinical review.

18. Periodontal scaling and root planing are a Benefit once per quadrant or site in a two (2) year period.

19. Localized delivery of antimicrobial agents may be performed at six (6) weeks to six (6) months after initial therapy (scaling and root planing or surgery) on no more than two (2) sites per quadrant, with pocket depth at least five (5) millimeters and less than ten (10) millimeters.

    a. If different teeth are treated in the quadrant within twelve (12) months, the treatment is not a Benefit.

    b. If the same teeth are re-treated within twenty-four (24) months, the treatment is not a Benefit.

20. 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.

21. Gingivectomy or gingivoplasty to allow access for a restorative procedure is considered part of the restorative procedure.

22. A bone replacement graft, biologic materials, or guided tissue regeneration in conjunction with an apicoectomy, gingivectomy, crown lengthening, retrograde filling, root amputation, periradicular surgery, soft tissue grafts, subepithelial tissue grafts, extraction, implant site, ridge augmentation, anatomical crown exposure, wedge procedure, or an apically positioned flap is a Specialized Procedure and not a Benefit.

23. Extra-oral soft tissue grafts (grafting of tissues from outside the mouth to oral tissues) or bone graft accession from a donor site is not a Benefit.

24. Separate fees for crown lengthening in the same site are Disallowed when charged by the same Provider or dental office within three (3) years.

25. Additional fees for more than two (2) quadrants of osseous surgery on the same day of service are Disallowed.

26. Separate fees for postoperative visits and/or dressing changes by the same Provider or dental office performing the treatment are Disallowed.

27. Refer to “General Limitations and Exclusions” for additional provisions that may apply.

H. 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 and Cast Restorations, 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.

Implants: Specified services, including repairs, and related prosthodontics. A crown Benefit is considered the same whether it is placed on a natural tooth or an implant.

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

TMD Treatment: Medically Necessary treatment of Temporomandibular Joint Disorder, including related diagnostic imaging.

I. Limitations on Major Services

1. Replacement of cast restorations (including veneers, crowns, pontics, inlays, and onlays) and associated procedures (such as cores and substructures) on the same tooth are not a Benefit if the previous placement is less than five (5) years old.
2. Inlays are not a Covered Service and will be optioned to an amalgam or resin restoration.
3. Veneers are not a Covered Service and will be optioned to a resin restoration.
4. Replacement of a bridge or denture is not a Benefit if the previous placement is less than five (5) years old.
5. 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.
6. Cantilever bridges are beyond the standard of care customarily provided and are subject to clinical review.
7. Overdentures are not a Covered Service.
8. Substructures are only a Benefit when necessary to retain a cast restoration due to the extensive loss of tooth structure from caries or fracture. Substructures are Disallowed when enough tooth structure is present to retain a cast restoration.
9. The fee for a core build-up and/or substructures is Disallowed when performed in conjunction with inlays, onlays, ¾ crowns, and veneers.
10. 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.

11. A separate fee for the recementation or re-bond to crowns, implants, inlays, onlays, posts and cores, veneers, or bridges within six (6) months of the original treatment by the same Provider or dental office is Disallowed.

12. A separate fee for the repair to crowns, inlays, onlays, or veneers within twenty-four (24) months of the original treatment by the same Provider or dental office is Disallowed.

13. A separate fee for the repair to crowns, inlays, onlays, or veneers within twenty-four (24) months of the original treatment by a different Provider or dental office is not a Benefit.

14. Services for the recementation, re-bond, or repair to crowns, implants, inlays, onlays, posts and cores, veneers, or bridges are a Benefit once per twelve (12) months. Procedures to modify existing partials and dentures are considered construction of prosthesis, not the repair of prosthesis.

15. A pontic required due to spaces in excess of those resulting from the extraction of the normal complement of natural teeth is a special condition of that patient's mouth and is not a Benefit.

16. Surgical placement of an implant body is a Benefit once per tooth per five (5) year period.

17. Implant supported prosthetics and/or abutment supported crowns are not a Benefit if the previous placement is less than five (5) years old. This limitation applies to the placement of crowns on natural teeth, abutment supported crowns on implants, and fixed partial denture pontics.

18. Implant maintenance procedures are limited to twice in a Benefit Period.

19. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure are subject to these limitations and/or exclusions:

    a. A separate fee is Disallowed when the procedure is performed in conjunction with routine cleanings, periodontal maintenance, root planing and scaling, gingival flap procedures, periodontal osseous surgery, or debridement of a peri-implant defect.

    b. This Benefit is limited to once per tooth per twenty-four (24) months.

    c. A separate fee for this procedure by the same Provider or dental office within twenty-four (24) months of initial therapy is Disallowed.

    d. A separate fee is Disallowed when this procedure is performed within twelve (12) months of implant-supported crown or bridge procedures by the same Provider or dental office.

20. Stress breaker, semi-precision, or precision attachments or the replacement of an implant/abutment supported prosthesis is considered an optional service and is not a Benefit.

21. A separate fee for the removal of an implant within twenty-four (24) months of the original placement, by the same Provider or dental office, is Disallowed. After twenty-four (24) months, this service is a Benefit once per tooth per lifetime.

22. A separate fee is Disallowed for a radiologic surgical implant index.
23. 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.
24. Temporary restorations, temporary implants, and temporary prosthodontics are considered part of the final restoration. A separate fee by the same Provider or dental office is Disallowed.
25. Benefits for porcelain crowns or porcelain supported prosthetics on posterior teeth are limited to premolars 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.
26. Maxillofacial prosthetics and related services are not a Benefit.
27. Crowns, implants, prosthodontics, and all related services are not Benefits for Enrollees under the age of sixteen (16).
28. 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.
29. Tissue conditioning is not a Benefit more than twice per denture unit in a three (3) year period.
30. Treatment of Temporomandibular/Craniomandibular Disorders (TMD) is covered within the scope of dental practice and does not include coverage for orthodontic appliances and treatment, crowns, bridges, and dentures unless the disorder is trauma related.
31. Refer to “General Limitations and Exclusions” for additional provisions that may apply.

J. Orthodontic Services

Orthodontic Services are procedures performed by a Provider using appliances to treat poor alignment of teeth and their surrounding structure. The Benefit determination for the Orthodontic Lifetime Maximum 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 Dental Plan Benefits to verify if this Plan includes coverage for Orthodontic Services along with specific and lifetime Benefit provisions.

Diagnostic casts will be considered for payment at the Diagnostic and Preventive Services Coinsurance level when performed in conjunction with covered Orthodontic Services. Payments for diagnostic casts are part of the Orthodontic Lifetime Maximum.

K. 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 are determined based on the total cost and total months of treatment.
3. Benefits will end immediately if orthodontic treatment is stopped.
4. Charges to repair or replace any orthodontic appliance (including, but not limited to, retainers and replacement retainers) are not covered, even when the appliance was a covered Benefit under this or any other Plan.
5. Charges for radiographic images (except for cephalometric radiographic images) and extractions are not covered under Orthodontic Services.
6. Oral/facial photographic images and diagnostic casts are a Benefit once per orthodontic treatment case. Additional fees for these procedures are Disallowed when performed by the same Provider or dental office.
7. Self-directed or "at-home" orthodontic treatment is not a Benefit.
8. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

L. General Limitations and Exclusions

1. Services for any covered procedures which exceed the frequency or age limitation shown in the Summary of Dental Plan 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.
2. Services beyond treatment that is considered the standard of care customarily provided are considered "optional or specialized services." These services may include the use of alternative techniques, special materials, and services of a cosmetic intent.
    a. If an Enrolled Person receives optional or specialized services, Benefits may be provided based on the customary or standard procedure. A determination of optional or specialized 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 or specialized services and any Benefit payable.
3. Charges for cone beam CT capture and interpretation services are not a Benefit.
4. 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.
5. Treatment to restore tooth structure lost from wear is not covered.
6. Cosmetic surgery or procedures are not covered.

7. Prosthodontic services or any single procedure started before the patient is covered under this Plan is not eligible for Benefits.
8. Prescribed drugs, pain medications, desensitizing medications, therapeutic drug injections, and non-invasive physical therapies are not covered unless part of a Medically Necessary TMD treatment plan and subject to approval by Delta Dental.
9. 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.
10. A separate fee for a consultation with a medical care professional is Disallowed.
11. A separate fee for certified translation or sign language services is Disallowed.
12. Dental case management services are subject to these limitations and/or exclusions:
    a. A separate fee for addressing appointment compliance barriers is Disallowed.
    b. A separate fee for care coordination is Disallowed.
    c. Motivational interviewing is not a Benefit.
        i. If this service is performed on the same date of service as nutritional counseling for control of dental disease, tobacco counseling for the control and prevention of oral disease, or oral hygiene instructions, a separate fee for this service is Disallowed.
    d. Patient education to improve oral health literacy is not a Benefit.
        i. If this service is performed on the same date of service as nutritional counseling for control of dental disease, tobacco counseling for the control and prevention of oral disease, or oral hygiene instructions, a separate fee for this service is Disallowed.
13. Orthodontic Services, or any services related to an orthodontic treatment plan, are not covered unless stated in the Summary of Dental Plan Benefits.
14. Treatment must be provided by a licensed Dentist or a person who by law may work under a licensed Dentist's direct supervision.
15. A separate charge for office visits, non-diagnostic consultations, case presentations, or cancelled or missed appointments is not covered.
16. Administrative services, including to duplicate/copy patient records, are not Covered Services.
17. Treatment to correct harmful habits is not covered.
18. A separate charge is Disallowed 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. Services or Supplies, as determined by Delta Dental, that are Experimental or Investigational in nature are not covered. This includes Services and Supplies required to treat complications from Experimental or Investigational procedures.
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 and related services are not a Benefit unless part of a Medically Necessary TMD treatment plan and subject to approval by Delta Dental.
26. Replacement of existing restorations (fillings) for any purpose other than treating active tooth decay or fracture is not covered. A tooth fracture or crack is defined as tooth structure that is mobile and/or separated from the natural tooth structure.
27. Charges for treatment of craze lines are not a Benefit. A “craze line” is a visible micro-fracture located in coronal enamel that does not break or split the continuity of the tooth structure.
28. Sales tax is not a Benefit.
29. Separate fees are Disallowed for procedures which are routinely considered by Delta Dental to be part of another service, if performed by the same Provider or dental office on the same date of service.
30. Services or Supplies excluded by the policies and procedures of Delta Dental, including the Processing Policies, are not a Benefit.
31. Services or Supplies for which no charge is made, for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage are not covered by the Plan.
32. Services or Supplies received due to an act of war or terrorism, declared or undeclared, are not a Covered Service.
33. Services or Supplies that are not within the categories of Benefits selected by your employer or organization and that are not covered under the terms of this Handbook are not a Benefit.

IV. Coordination of Benefits

Coordination of Benefits (COB) applies to this Plan when an Enrollee has dental benefits under more than one plan. The objective of COB is to make sure the combined payments of the plans are no more than your actual dental bills. COB rules establish whether this Plan's Benefits are determined before or after another plan's benefits.

An Enrolled Person will provide Delta Dental with the information needed to administer COB. Delta Dental may release required information or obtain required information in order to coordinate the Benefits of an Enrolled Person.

Delta Dental follows National Association of Insurance Commissioners (NAIC) guidelines for COB.

A. Determining Which Plan is Primary

To determine which plan is primary, Delta Dental considers which Enrollee of a family is involved in a claim and the coordination provisions of the other plan. The primary plan is determined by the first of the following rules that applies:

1. **Medicaid or Indian Health Services** – Delta Dental is always the primary plan to any benefits payable by Medicaid or Indian Health Services.

2. **Non-Coordinating Plans** – If you have another plan that does not coordinate benefits, it will always be the primary plan.

3. **Hospital, Surgical/Medical, or Prescription Drug Plans** – These are the primary plan if the plan provides benefits for dental-related services including but not limited to: treatment due to accidental injuries, surgical extraction of impacted wisdom teeth, oral surgery, the administration of general anesthesia, and Temporomandibular Joint Disorder.

4. **Employee or Subscriber** – The plan that covers the Enrolled Person other than as an Enrolled Dependent is primary. For example, the plan that covers you as the employee or Subscriber, neither laid off nor retired, is the primary plan.

5. **Children and the Birthday Rule** – The plan of the parent whose birthday is earliest in the calendar year is always primary for children. For example, if your birthday is in January and your Spouse's birthday is in March, your plan will be primary for all of your children. If both parents have the same birthday, the plan that has covered the parent for the longer period will be primary.

6. **Children with Parents Divorced or Separated**

    a. If a court decree makes one parent responsible for health care expenses, that parent's plan is primary.

    b. If a court decree states that the parents have joint custody without stating that one of the parents is responsible for the child's health care expenses, Delta Dental follows the birthday rule (see rule 5 above). If neither of these rules applies, the order will be determined as follows:

i. First, the plan of the parent with custody of the child;

ii. Then, the plan of the Spouse of the parent with custody of the child;

iii. Next, the plan of the parent without custody of the child; and

iv. Last, the plan of the Spouse of the parent without custody of the child.

7. **Laid-Off or Retired Enrollees** – The plan that covers the Enrollee as a laid-off or retired employee or as a dependent of a laid-off or retired employee.

8. **COBRA Coverage** – The plan that is provided under a right of continuation pursuant to federal or a similar state law (that is COBRA).

9. **Other Plans** – If none of the rules above determines the order of benefits, the plan that has covered the Enrollee for the longer period will be primary.

B. How Delta Dental Pays as Primary

When Delta Dental is the primary plan, Delta Dental will pay for Covered Services as if you had no other coverage.

C. How Delta Dental Pays as Secondary

When Delta Dental is the secondary plan, it will pay for Covered Services based on the amount left after the primary plan has paid. It will not pay more than that amount, and it will not pay more than it would have paid as the primary plan. However, Delta Dental may pay less than it would have paid as the primary plan if the balance is lower than that amount.

D. Right of Recovery

If Delta Dental pays more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The people it has paid or for whom it has paid;

   a. Insurance companies; or

   b. Other organizations.

V. Claims Appeal

A. Voluntary Appeal Procedure

1. 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.

2. 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:

    a. will be notified in writing by Delta Dental of any Adverse Benefit Determination and the reason(s) for the Adverse Benefit Determination;

    b. 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;

    c. 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;

    d. may choose a Representative to act on his or her behalf at the Enrolled Person's expense;

    e. will not be charged any fees or costs incurred by Delta Dental as part of the voluntary appeals process;

    f. has one hundred eighty (180) days following receipt of a notification of an Adverse Benefit Determination within which to appeal;

    g. will receive a response to the appeal from Delta Dental in writing within thirty (30) days of receipt of the request;

    h. is not required to file an appeal prior to arbitration or taking civil action;

    i. 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;

    j. may also appeal an Adverse Benefit Determination to the Consumer Relations Division of the New Mexico Office of Superintendent of Insurance.

B. Informal Claim Review Process

Most claim-related requests may be handled informally by calling the Delta Dental Customer Service 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 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 one hundred eighty (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 Plan Benefit provision which resulted in an Adverse Benefit Determination.

    a. 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.

    b. 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 Claim 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 Dental Consultant. Three (3) voluntary options for appeal are available:

    a. 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 Enrolled Person wishes to be considered. A 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.

        i. 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 Provider. In the event the second consulting Dentist also determines the treatment was not Dentally Necessary according to the terms of the 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.

    b. 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 additional information the Enrolled Person wishes to be considered. A 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.

i. 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.

ii. In the event the second consulting Dentist determines the treatment was not Dentally Necessary according to the terms of this Plan 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 this Plan's 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 Provider. In the event the examining Dentist determines the treatment was not Dentally Necessary according to the terms of this Plan 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 Provider, as appropriate.

c. 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.

D. Grievance

No person shall be subject to retaliatory action by Delta Dental for any reason related to a grievance. All written appeals must be directed to Delta Dental, Attention: Claims Manager, 2500 Louisiana Blvd. NE STE 600, Albuquerque, New Mexico, 87110.

E. Office of Superintendent of Insurance

Contact the New Mexico Office of Superintendent of Insurance (OSI) at any time for assistance with a claim appeal:

Office of Superintendent of Insurance
1120 Paseo de Peralta
Santa Fe, NM 87501
Phone: 1-855-4-ASK-OSI

F. New Mexico Board of Dental Health Care

Contact the New Mexico Board of Dental Health Care to file a complaint about a Provider:

NM Board of Dental Health Care
P.O. Box 25101
Santa Fe, NM 87504
Phone: (505) 476-4622 (ask for the Compliance Liaison)

VI. Termination of Coverage

A. When Coverage for an Enrolled Person Ends

1. Unless stated otherwise in the Summary of Dental Plan Benefits, coverage ends on the last day of the month for which Premium is paid for an enrolled Subscriber who loses coverage due to:

   a. loss of eligibility;

   b. voluntary cancellation of coverage;

   c. cancellation of this Plan by your Group or Delta Dental;

   d. 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 Subscriber as an Enrollee and Premium is paid on the Enrollee's behalf.

2. An Enrolled Dependent loses coverage along with the enrolled Subscriber, or on the last day of the month in which dependent status is lost, whichever is earlier. Coverage for dependent children who reach age twenty-six (26) will automatically be terminated by Delta Dental on the last day of the month in which the dependent child turns age twenty-six (26) unless Delta Dental receives proof of the dependent child's qualification for extended eligibility. Refer to the Summary of Dental Plan Benefits for any exceptions to the age twenty-six (26) limitation.

3. A Subscriber and/or dependent may be eligible to continue coverage depending on the size of the Group and if certain conditions are met. Please refer to Section VII, "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 twelve (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 of 1985 (COBRA). 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 this 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

Delta Dental understands that medical and health information is private and is committed to protecting the confidentiality and security of that information. Delta Dental provides a Notice of Privacy Practices in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Notice describes how medical information about you may be used and disclosed and how you can get access to this information. The Notice is available on **www.deltadentalnm.com** in the footer of the site.

If you have questions about the Notice or want to request a copy, please call (800) 999-0963, send an email to **HIPAAprivacy@deltadentalnm.com**, or contact the Chief Privacy Officer:

Delta Dental of New Mexico
Chief Privacy Officer
P.O. Box 30416
Lansing, MI 48909-7916
(517) 347-5451

You can also request information about Delta Dental's general privacy policies by using the above contact information.

X. General Conditions

A. Assignment

Services and Benefits are for the personal Benefit of Enrolled Persons and cannot be transferred or assigned, except as otherwise stated in Section II(E) of this Handbook.

B. Subrogation and Right of Reimbursement

If Delta Dental provides Benefits under this Plan and you have a right to recover damages from another, Delta Dental is subrogated to that right.

To the extent that this Plan provides or pays Benefits for Covered Services, Delta Dental is subrogated to any right you or your Eligible Dependent has to recover from another, his or her insurer, or under his or her "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions. You or your legal representative must do whatever is necessary to enable Delta Dental to exercise its rights under this provision.

If you or your Eligible Dependent recovers damages from any party or through any coverage named above, you must reimburse Delta Dental from that recovery to the extent of payments made under this Plan.

C. Obligation to Assist in Delta Dental's Reimbursement Activities

If you are involved in an automobile accident or require Covered Services that may entitle you to recover from a third party and Delta Dental advances payment to prevent financial hardship to you or your family, you and your Eligible Dependents have an obligation to help Delta Dental obtain reimbursement for the amount of the payments advanced for which another source was also responsible for making payment. You and your Eligible Dependents are required to provide Delta Dental with information about other insurance coverage (including, but not limited to, automobile, home, and other liability insurance coverage, and coverage under another health plan), and the identity of any other person or entity, and his or her insurers (if known), that may be obligated to provide payments or benefits for the same Covered Services that Delta Dental already paid.

D. Right of Recovery Due to Fraud

If Delta Dental pays for services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a claim that contains false or misrepresented information, or pays a claim that is determined to be fraudulent due to your acts or acts of your Enrolled Dependents, it may recover that payment from you or your Enrolled Dependents. Delta Dental may recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you or your Enrolled Dependents. Delta Dental will provide an explanation of the payment recovery at the time the deduction is made.

E. Actions

No action on a legal claim arising out of or related to this Plan shall be brought against Delta Dental without first providing Delta Dental sixty (60) days' written notice of the legal claim, unless prohibited by applicable state law. In addition, no action shall be brought more than three (3) years after the legal claim first arose (or after exploration of the applicable statute of limitations, if that is longer). Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude you from seeking a judicial decision or pursuing other available legal remedies.

F. Governing Law

This Plan will be governed by and interpreted under the laws of the state of New Mexico.

G. Legally Mandated Benefits

If any applicable law requires broader coverage or more favorable treatment for you or your Enrolled Dependents than is provided by this Plan, that law shall control over the language of this Handbook and the Summary of Dental Plan Benefits.

XI. Definitions

Adverse Benefit Determination: Any denial, reduction, or termination of the Benefits for which you filed a claim. Or, a failure to provide or to make payment (in whole or in part) of the Benefits you sought, including any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which Benefits are otherwise provided was Experimental or Investigational, or was not Medically Necessary or appropriate.

Allowed Amount: The Maximum Approved Fees determined by Delta Dental and considered for each dental procedure before application of Coinsurance and Deductible.

Benefit Period: The time period during which the Deductible and Maximum Benefit Amount accumulate and frequency limitations apply, as shown in the Summary of Dental Plan 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 Dental Plan Benefits.

Coinsurance: The percentage of the dental Provider's approved fee due from the Enrolled Person to the dental Provider.

Contract: The NMRHCA Professional Services Contract, Dental Benefit Handbook, Summary of Dental Plan Benefits and, if applicable, successor agreements, or renewals now or hereafter issued or executed.

Covered Services: The unique dental services selected for coverage as described in the Summary of Dental Plan Benefits and subject to the terms of this Handbook.

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.

Delta Dental Member Company: An individual benefit plan that is a member of the Delta Dental Plans Association, the nation's largest, most experienced system of dental health plans.

Dental Benefit Handbook: This document. Delta Dental will provide Benefits as described in this Handbook. Any changes in this Handbook will be based on changes to the Contract between Delta Dental and your employer or organization.

Dental Consultant: An independent contractor paid by Delta Dental of New Mexico to conduct claims review. The review of dental insurance claims is defined in the practice of dentistry in the New Mexico Dental Practice Act. A Dental Consultant must be a licensed Dentist.

Dental Necessity (Dentally Necessary): 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.

Disallowed: A fee for a service that is Disallowed is not Benefited by Delta Dental, nor collectable from the patient by the Participating Provider.

Domestic Partner: A Domestic Partner, as defined by the Group or as otherwise required by law, is treated the same as a Spouse for Benefit determinations and Plan administration. Domestic Partners are covered unless stated otherwise in the Summary of Dental Plan Benefits.

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

Eligible Retiree: A retiree who meets the conditions of eligibility outlined in Section I, "Eligibility and Enrollment," whether or not actually enrolled.

Enrolled Dependent: An Eligible Dependent whose completed enrollment information has been received and accepted by Delta Dental, and for whom Premium is paid.

Enrolled Person or Enrollee: An Enrolled Retiree, 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 accepted by Delta Dental, and for whom Premium is paid.

Enrolled Retiree: An Eligible Retiree whose completed enrollment information has been received and accepted by Delta Dental, and for whom 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 government 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 government bodies;
2. The scientific evidence as published in peer-reviewed 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.

Group: The New Mexico Retiree Health Care Authority (NMRHCA).

Independent Licensed Dentist: A licensed Dentist who is actively practicing dentistry.

Maximum Approved Fee: The Maximum Approved Fee is the lowest of: (a) the Submitted Amount; (b) the lowest fee regularly charged, offered, or received by an individual Provider for a dental Service or Supply, irrespective of the Provider's contractual agreement with another dental benefits organization; or (c) the maximum fee that the local Delta Dental Plan approves for a given procedure in a

given region and/or specialty based upon applicable Participating Provider schedules and internal procedures. Participating Providers agree not to charge Delta Dental patients more than the Maximum Approved Fee for a Covered Service. In all cases, Delta Dental will make the final determination regarding the Maximum Approved Fee for a Covered Service.

Maximum Benefit Amount: The maximum dollar amount Delta Dental will pay in a Benefit or lifetime Period for Covered Services for each Enrolled Person.

Medical Necessity (Medically Necessary): Means that a dental item or service satisfies each of the following criteria: (a) is recommended by a Dentist or other qualified dental professional practicing within the scope of his or her license who has personally evaluated the patient; (b) is essential to and provided for prevention, evaluation, diagnosis, or treatment of the patient's dental condition, disease, or injury; (c) is consistent with the symptoms, finding, and diagnosis related to the patient's dental condition, disease, or injury; (d) is clinically appropriate for diagnosis and treatment of the patient's dental condition, disease, or injury in terms of type, frequency, extent, site, and duration of the intervention; (e) is considered to be effective intervention for the patient's dental condition, disease, or injury which can reasonably be expected to have beneficial health outcomes that outweigh potential harmful effects; (f) is performed in accordance with relevant credible scientific evidence and generally accepted professional standards of care; and (g) is required for reasons other than the convenience of the patient or treating Provider. Delta Dental may use Dental Consultants to determine Medical Necessity.

Non-Participating Approved Amount: The maximum fee allowed per procedure for services rendered by a Non-Participating Provider as determined by Delta Dental.

Non-Participating Provider: A Provider who has not signed a contract with any Delta Dental Plan to participate in any of Delta Dental's Provider networks. Non-Participating Providers do not accept Delta Dental's Maximum Approved Fees as payment in full. Non-Participating Providers may bill the patient the full submitted charge as well as any charges for Disallowed services.

Open Enrollment: A period of time specified by the Group to allow eligible persons to enroll in this Plan or to cancel coverage under this Plan for the renewed Contract period.

Out-of-Country Provider: A Provider whose office is located outside the United States and its territories. Out-of-Country Providers are not eligible to sign participating agreements with Delta Dental.

Participating Provider: A Provider who has agreed to abide by a Delta Dental Participating Provider Agreement.

Premium: The monthly amount due to Delta Dental for Enrolled Persons.

Pre-Treatment Estimate: A written estimate issued by Delta Dental that outlines dental Benefits that may be available under your coverage for your proposed dental treatment. A Pre-Treatment Estimate is voluntary and optional unless specified in the Summary of Dental Plan Benefits.

Processing Policies: Delta Dental's policies and guidelines used for Pre-Treatment Estimates and payment of claims. The Processing Policies may be amended from time to time.

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

Qualifying Event: A specific, qualified circumstance that alters the eligibility status of an Enrollee or Eligible Dependent under the Group dental Plan. Qualifying Events include but are not limited to: marriage, birth, divorce, and involuntary loss of other coverage. The changes an Enrollee or Eligible Dependent makes to coverage due to a Qualifying Event must be consistent with that particular event. Events may affect eligibility differently. You must notify Delta Dental in a timely manner through your employer or organization of any event that changes the eligibility status of an Enrollee or Eligible Dependent. With respect to Qualifying Events that require the enrollment of an individual into this Plan, including but not limited to marriage, birth, or adoption, Delta Dental must receive notification of such Qualifying Event within thirty-one (31) days of such Qualifying Event. Delta Dental may require proof of the Qualifying Event.

Services and Supplies: Those Services, Supplies, or devices 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, Supplies, or devices. 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.

Specialized Procedure: The term "Specialized Procedure" describes a dental service or procedure that is used when unusual or extraordinary circumstances exist and is not generally used when conventional methods are adequate.

Spouse: The individual legally married to a Subscriber as determined and recognized by New Mexico state law.

Submitted Amount: The amount a Provider bills to Delta Dental for a specific treatment or service. A Participating Provider cannot charge you or your Enrolled Dependents for the difference between this amount and the Maximum Approved Fee.

Subscriber: Means all people who are members or employees of the Group specified in the Summary of Dental Plan Benefits, are certified as being eligible by the Group, and are enrolled to receive Benefits under this Plan.

Summary of Dental Plan Benefits: A description of the specific provisions of your dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Handbook. To the extent that anything set forth in this Handbook conflicts with your Summary of Dental Plan Benefits, your Summary of Dental Plan Benefits will control.

Temporomandibular Joint Disorder (TMD): A disorder and/or dysfunction associated with temporomandibular/craniomandibular structure.

This Plan: The dental coverage established for eligible persons pursuant to this Handbook.

Delta Dental of New Mexico
2500 Louisiana Blvd. NE STE 600
Albuquerque, NM 87110
(505) 855-7111
(877) 395-9420
www.deltadentalnm.com