DELTA DENTAL®

ALBUQUERQUE PUBLIC SCHOOLS

# *Dental Benefits Handbook*

## *Plan Benefits Administered For Albuquerque Public Schools by Delta Dental of New Mexico*

We do dental. *Better.*

**Welcome to the growing number of people who receive dental coverage administered by Delta Dental of New Mexico.**

This Dental Benefit Handbook, together with the Summary of Benefits and the Plan information provided to you by Albuquerque Public Schools describes important benefit and eligibility provisions.

Benefits under the dental Plan are provided by Albuquerque Public Schools, a Plan Sponsor for the exclusive benefit of eligible persons and their qualified dependents. The Plan Sponsor established the Plan as a self-funded dental Plan for the purpose of providing dental coverage and reserves the right to change or amend any or all provisions of the Plan and to terminate the Plan at any time. Any modification of the Plan will apply to all persons who are covered by the Plan at the time of such change. Plan Participants will be notified in writing by the Plan Sponsor of any material changes to the Plan.

Delta Dental of New Mexico (Delta Dental) has been selected by the Plan Sponsor to process claims under the Plan. Delta Dental does not serve as an insurer, but as a claims processor. Claims for benefits are sent to Delta Dental for benefit determination and claims payment. Delta Dental also administers enrollment, customer service, and the Delta Dental provider network(s) selected by the Plan Sponsor. Delta Dental has a contractual agreement to provide claims and other administrative services on behalf of the Plan Sponsor but the Plan Sponsor, not Delta Dental, has sole responsibility for providing dental coverage under the Plan.

Please take time to become familiar with the dental coverage. For answers to questions about the benefits, please call:

**Delta Dental Benefit Services Department**
**(505) 855-7111**
**or**
**toll free (877) 395-9420**

Good oral health is an important part of good general health. The dental Plan benefits are designed to promote regular dental visits. Take advantage of the Plan by calling a Delta Dental dentist who participates in PPONew Mexico today for an appointment.

For a current listing of Delta Dental dentists in New Mexico, visit the Find a Dentist area of the website at **DeltaDentalNM.com, click on the link which allows you to view a PDF, then select PPONew Mexico.**

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# I. HOW THE PLAN WORKS

## A. Delta Dental Provider Networks Information

1. The provider network which is considered "In-Network" inside the state of New Mexico is called PPONew Mexico. Outside of New Mexico, Delta Dental PPO providers are considered In-Network. Delta Dental has multiple provider networks and not all Delta Dental dentists participate in these two networks. Out-of-pocket costs can be much higher if services are received from an out-of-network Delta Dental dentist or from a dentist who does not participate at all with Delta Dental, so it is important to receive services from In-Network dentists whenever possible.

    - Delta Dental dentists will not bill a Delta Dental patient for any amount over the Delta Dental Maximum Approved Fee applicable to the service provided and the provider agreement with Delta Dental. Members are protected from "balance bill" charges in excess of the applicable maximum.

    - Delta Dental dentists have agreed to bill Delta Dental for amounts over and above the estimated patient share of the treatment cost, avoiding the need for members to pay for the entire cost of the treatment then wait for reimbursement. As indicated on the Summary of Benefits, a patient's share of the cost for any covered service may vary based on whether the dentist participates in PPONew Mexico or, if outside of New Mexico, in the Delta Dental PPO provider network. Members have direct access to Delta Dental dentists. Availability and appointment scheduling is always independently determined by each individual dentist, not by Delta Dental.

    - Pre-selection of a dentist is never required. Each member of the family may use a different dentist.

## B. How Benefit Payment is Based on the Dentist Selected

1. If a dentist participates in PPONew Mexico (or Delta Dental PPO if outside of New Mexico), all services received from that dentist are considered In-Network.

2. If a dentist participates only in Delta Dental Premier, but not in PPONew Mexico (in New Mexico) or Delta Dental PPO (if in another state) the dentist is considered out-of-network.

    - These out-of-network Delta Dental dentists are allowed to balance bill patients only up to Delta Dental Premier Maximum Approved Fees. Because the amount of balance billing is limited, the additional out-of-pocket costs may be lower than when services are received from an out-of-network dentist who does not participate in Delta Dental Premier.

3. Non-participating dentists are dentists who do not participate in *any* Delta Dental dentist network. Benefits apply for covered services received from a non-participating dentist, however:

    - These dentists are not subject to agreements which would require them to honor Delta Dental pricing maximums for the services they provide;

    - Non-participating dentists may bill their patients up to the full amount of their submitted charges, and they are not subject to Delta Dental fee maximums.;

- Non-participating dentists are not subject to other member protections, such as guarantees on restorative services, which are required of dentists who participate with Delta Dental;
- Payments made by Delta Dental, on behalf of the Plan, for services received from a non-participating provider may be paid to the provider or directly to the Primary Plan Participant, depending on the state in which the services were received and whether there was a valid Assignment of Benefits. Plan Participants may be responsible for payment at the time services are received for the full amount due if required by the non-participating provider.

Maximize benefits by selecting, whenever possible, an In-Network Delta Dental dentist. For online access to New Mexico provider directories, or to search for a dentist nationally, visit the website at DeltaDentalNM.com and click on the Find a Dentist tab. To locate an in-network dentists, be sure to select PPONew Mexico for services in New Mexico or Delta Dental PPO if seachinig for a provider in another state.

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

## C. Accessing Benefits

To use the Plan, follow these steps:

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

   If the services performed outside the United States are for anterior crowns or bridges an x-ray of the area must be obtained prior to the service being considered for benefits. Plan Participants are responsible for obtaining the necessary documentation for services provided, for filing a claim with Delta Dental, and for

payment to the dentist at the time services are performed. Delta Dental will calculate foreign currency benefit payments based on published currency conversion tables that correspond to the date of service.

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

6. Within 30 days of receiving a valid claim, Delta Dental will send an Explanation of Benefits which records Delta Dental's benefit determination on behalf of the Plan, any payment made by Delta Dental on behalf of the Plan, and any amount still owed to the dental provider. The Explanation of Benefits will be mailed to the Primary Plan Participant, or other appropriate beneficiary, and to the treating dentist if a Delta Dental participating dentist. The 30-day period for claim determination may be extended an additional 15 days if matters beyond the control of Delta Dental delay benefit determination. Notification of any necessary extension will be sent prior to the expiration of the initial 30-day period.

7. If a claim for benefits is reduced or denied, the Explanation of Benefits will state the reason for the adverse determination. Should a Plan Participant believe Delta Dental incorrectly denied all or part of a claim, a review may be requested by following the steps described in Section V, "Claims Appeal."

## D. Out-of-Pocket Expenses

The coverage is designed for cost sharing between Plan Participants and the Plan for the services provided by a dental provider.

### 1. Deductible

The Plan requires Plan Participants to pay a portion of the initial expense toward some covered services in each benefit period. The amount of this deductible is stated in the Summary of Benefits.

### 2. Patient Copayment

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

### 3. Maximum Benefit Amount

The Plan will pay for covered services up to a maximum amount for each Plan Participant for each benefit period. Plan Participants are responsible for payment of amounts due for any dental services that exceed the maximum during the benefit applicable in the benefit period. The maximum benefit amount is stated in the Summary of Benefits.

## E. Predetermination of Benefits

A predetermination of benefits is not required as a condition for payment of benefits. However, if extensive dental work is needed, Delta Dental recommends that a

predetermination of benefits be obtained prior to the services being performed. A predetermination of benefits provides both the patient and the dentist with an estimate of the benefit levels, maximums, and limitations that may apply to a proposed treatment plan. Most importantly, the Plan Participant's share of the cost will be estimated.

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

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

## F. Clinical Review

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

## G. To Whom Benefits are Paid

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

## H. Right to Recover Benefits Paid By Mistake

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

# II. BENEFITS, LIMITATIONS AND EXCLUSIONS

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

## A. Diagnostic and Preventive Services

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

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

**Preventive**: cleanings, application of fluoride, space maintainers and sealants.

### Limitations on Diagnostic and Preventive Services

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

12. A separate fee for the recementation or repair to a space maintainer by the same provider is not allowed within six (6) months of the original treatment. Six (6) months after the original treatment date, recementation or repair is a benefit once per twelve (12) month period.

13. A separate fee for the removal of a space maintainer by the same provider who placed the initial appliance is not allowed.

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

## B. Restorative Services

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

### Limitations on Restorative Services

1. A separate fee for the replacement of a restoration or any component of a restoration on a tooth for the same surface by the same provider is not allowed if done within twenty-four (24) months of the initial service.

2. When multiple restorations involving multiple surfaces of the same tooth are performed, benefits will be limited to that of a multi-surface restoration. A separate benefit may be allowed for a non-contiguous restoration on the buccal or lingual surface(s) of the same tooth subject to clinical review.

3. Resin restorations in posterior teeth are limited to bicuspid and maxillary first molars. On all other teeth, they are considered optional services and are limited to the equivalent amalgam restoration benefit.

4. Prefabricated resin crowns are a benefit for primary anterior teeth only.

5. Preventive restorations are not a covered benefit.

6. Services for metallic, porcelain/ceramic, or composite/resin inlays are limited to the benefit for the equivalent amalgam/resin procedure.

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

8. Replacement of existing restorations for any purposes other than restoring active tooth decay or fracture is not covered.

9. Separate fees for more than one pin per tooth or a pin performed on the same date of service as a build-up are not allowed. Pin retention, when dentally necessary, is allowed once per tooth in a twenty-four (24) month period.

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

## C. Basic Services

**Anesthesia**: intravenous sedation and general anesthesia.

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

**Extractions**: surgical and non-surgical extractions.

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

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

### Limitations on Basic Services

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

period. A gingivectomy performed on the same date of service as a restoration is an eligible expense.

18. Separate fees for crown lengthening in the same site are disallowed when charged by the same dentist within three (3) years.

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

20. Separate fees for postoperative visits and dressing changes by the same dentist performing the surgery are disallowed.

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

## D. Major Services

**No payment will be made by the Plan for Major Services unless stated in the Summary of Benefits.**

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

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

**Implants:** specified services, including repairs, and related prosthodontics, subject to clinical review and approval.

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

**Limitations on Major Services:**

1. Replacement of any crowns, cast restorations, build-ups, implants, substructures or veneers is not a benefit within five (5) years of previous placement.

2. Replacement of any bridge or denture is not a benefit if the previous placement is less than five (5) years old.

3. Services which are beyond the standard of care customarily provided, or not necessary to restore function are limited to the benefit applicable to a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.

4. Overdentures are not a covered service.

5. A separate fee for a crown build-up or substructure is disallowed when enough tooth structure is present to retain a cast restoration.

6. Posts and cores in addition to a crown are a benefit only on endodontically treated teeth. In addition to the requirement for endodontic treatment, anterior teeth must have insufficient tooth structure to support a cast restoration. Fees are disallowed when these requirements are not satisfied.

7. A separate fee for the recementation or repair to crowns, implants, onlays, post and core or bridges within six (6) months of the original treatment by the same provider is disallowed. After six (6) months, these services are a benefit once per twelve (12) months. Procedures to modify existing partials and dentures are considered construction of prosthesis versus the repair of a prosthesis.

8. Surgical placement of eposteal or transosteal implants is not a benefit.

9. Surgical placement of an endosteal implant is a benefit once per tooth per five (5) year period.

10. Implant retained or supported crowns and retainers with metallic alloy content less than high noble are not benefits.

11. Implant maintenance procedures are limited to twice in a benefit period.

12. The replacement of a semi-precision or precision attachment of an implant/abutment supported prosthesis is considered an optional service and is not a benefit.

13. Major services, or any services related to a Major Services treatment plan, are not covered unless stated in the Summary of Benefits.

14. A separate fee for the removal of an implant within twenty-four (24) months of the original placement, by the same provider, is disallowed. After twenty-four (24) months, this service is a benefit once per tooth per lifetime.

15. A separate fee is not allowed for a radiologic surgical implant index.

16. 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.

17. Temporary restorations, temporary implants and temporary prosthodontics are considered part of the final restoration. A separate fee by the same provider is not allowed.

18. Benefits for porcelain crowns or porcelain supported prosthetics on posterior teeth are limited to bicuspids 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.

19. Maxillofacial prosthetics are not a benefit.

20. Crowns, implants, prosthodontics and all related services are not benefits for dependents under the age of sixteen (16).

21. Fees for full or partial dentures include any reline/rebase, adjustment or repair required within six (6) months of delivery except in the case of immediate dentures. After six (6) months, adjustments to dentures are a benefit twice in a twelve (12) month period and relines or rebases are a benefit once in a three (3) year period.

22. Tissue conditioning is not a benefit more than twice per denture unit in a three (3) year period.

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

## E. Orthodontic Services

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

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

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

### Limitations on Orthodontic Services

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

## F. General Limitations and Exclusions

1. Services for any covered procedures which exceed the frequency or age limitation shown on the Summary of Benefits are not eligible for benefits. Unless stated otherwise, all frequency limitations are measured from the last date a procedure was performed according to the patient's dental records.
2. Services beyond treatment that is considered the standard of care customarily provided, or which are not necessary to restore function, are considered "optional or specialized services."

   If a Plan Participant receives optional services, benefits may be provided based on the customary or standard procedure. A determination of optional services is not an opinion or judgment on the quality or durability of the service. The Plan Participant will be responsible for any difference between the cost of optional services and any benefit payable.
3. 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.

4. Services for congenital or developmental malformations are not covered. Such malformations include, but are not limited to, cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), and fluorosis (a type of discoloration of the teeth). Services provided to newborn children enrolled from birth for congenital defects or birth abnormalities are not, however, excluded from coverage.

5. Treatment to restore tooth structure lost from wear unless there is visible decay or fracture on the tooth structure 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 the Plan are not eligible for benefits.

8. Prescribed drugs, pain medications, desensitizing medications and therapeutic drug injections are not covered.

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

11. Orthodontic services, or any services related to an Orthodontic treatment plan, are not covered unless stated in the Summary of Benefits.

12. Treatment of the temporomandibular joint disease (TMD) is not a covered expense.

13. Treatment must be provided by a licensed dentist or a person who by law may work under a licensed dentist's direct supervision.

14. A separate charge for office visits, non-diagnostic consultations, case presentations or broken appointments is not covered.

15. Treatment to correct harmful habits is not covered.

16. A separate charge is not allowed for behavior management, infection control, sterilization, supplies, and materials.

17. Charges for services or supplies that are not necessary according to accepted standards of dental practice are not benefits.

18. Charges for services, supplies, or devices which are not a dental necessity are not benefits.

19. Procedures considered experimental or investigational, as determined by Delta Dental, are not covered.

20. A hemisectioned tooth will not be benefited as two (2) separate teeth.

21. Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion is not a benefit.

22. Treatment to stabilize teeth is not a benefit.

23. Occlusal or athletic mouth guards are not a benefit.

24. Replacement of existing restorations for any purposes other than restoring active tooth decay or fracture are not covered.

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

## III. COORDINATION OF BENEFITS

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

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

### A. Medical and Dental Plans with Which the Plan Coordinates Benefits

1. Group contracts, health maintenance organization contracts, closed panel plans or other forms of group coverage, including non-insured plans and dental/medical benefits under group automobile contracts;

2. An insurance policy, a service plan contract, a pre-payment plan or other non-insured plan;

3. Medicare or any other governmental plan as permitted by law.

### B. Medical and Dental Plans with Which the Plan Does Not Coordinate Benefits

1. Accidental injury policy provided through a school;

2. Hospital or other fixed indemnity coverage, accident or specified disease coverage, Medicare supplement policies or Medicaid policies;

3. Individual policies or contracts.

### C. Which Plan Is Primary?

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

1. This Plan is always the primary plan to any benefits payable by Medicaid or Indian Health Services.

2. This Plan is the secondary plan to a group medical plan providing benefits for dental related services including but not limited to: treatment due to accidental injuries, surgical extraction of impacted wisdom teeth, oral surgery and the administration of general anesthesia.

3. A plan that does not provide for coordination of benefits (non-coordinating plan) will pay its benefits first.

4. Plan Participants other than Children

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

5. Children

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

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

6. Children of Divorced or Separated Parents

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

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

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

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

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

7. Continuation Coverage

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

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

## D. How This Plan Pays as Primary

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

### E. How This Plan Pays as Secondary

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

## IV. CLAIMS APPEAL

### A. Voluntary Appeal Procedure

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

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

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

## B. Informal Claim Review Process

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

## C. Formal Claim Appeal Process

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

1. Appeal of Claim Processing Procedure means the Plan Participant 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.

   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 Plan Participant wishes to be considered.

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

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

   - The Plan Participant 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 Plan Participant wishes to be considered. A licensed Delta Dental dental consultant, who is neither the individual who made the initial claim determination nor the subordinate of that individual, will provide a full and fair subsequent and independent review of the claim.

     If the second licensed Delta Dental 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 Plan Participant and the treating dentist. In the event the second licensed Delta Dental consulting dentist also determines the treatment was not dentally necessary according to Plan provisions or standard dental treatment, the adverse benefit determination will be upheld. Delta Dental will send notification to the Plan Participant and to the treating dental provider, as appropriate.

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

subordinate of that individual, will provide a full and fair independent review of the claim.

If the second licensed Delta Dental 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 Plan Participant and the treating dental provider, as appropriate.

In the event the second licensed Delta Dental consulting dentist determines the treatment was not dentally necessary according to Plan provisions or standard dental treatment, an oral examination will be scheduled with a mutually agreed upon licensed dentist. The fee for this oral examination will be the responsibility of Delta Dental and will not apply to the frequency limitations on exams under the Plan 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 Plan Participant and the treating dentist. In the event the examining dentist determines the treatment was not dentally necessary according the Plan provisions or standard dental treatment, the adverse benefit determination will be upheld. Delta Dental will send written notification to the Plan Participant and to the treating dentist, as appropriate.

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

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

## V. TERMINATION OF CLAIM PAYMENT SERVICES

### A. When Coverage for a Plan Participant Ends

Unless otherwise stated in the Summary of Benefits, coverage ends when a Primary Plan Participant loses coverage due to:

1. loss of eligibility as defined by the Plan Sponsor;
2. voluntary cancellation of coverage;
3. cancellation of the Plan;
4. entering an unapproved leave of absence.

### B. When Payment for Claims Ends

If a Plan Participant loses coverage, Delta Dental will only pay claims on behalf of the Plan for covered services incurred prior to the loss of coverage. To be considered for payment by Delta Dental, claims must be submitted to Delta Dental in writing within 12 months after the services have been provided and while the Plan Sponsor's administrative services contract is still in effect.

### C. Termination of the Plan Sponsor's Administrative Services Contract with Delta Dental

In the event the Administrative Services Contract between the Plan Sponsor and Delta Dental is canceled for any reason, including non-payment of Delta Dental's administration fees or the Plan Sponsor's failure to fund claims on a timely basis, Delta Dental will discontinue providing administrative and claims processing services and access to the Delta Dental dentist network on the date concurrent with the termination of the Administrative Services Contract.

## VI. CONTINUATION OF COVERAGE

The Plan Sponsor is subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. This means that a Plan Participant may be entitled to continue coverage under the Plan at his/her own expense under the Plan following certain qualifying events if certain conditions are met. The Plan Sponsor is responsible for providing notification of COBRA continuation rights and for any/all administration related to those COBRA rights.

## VII. PRIVACY NOTICE

Delta Dental Plan of New Mexico, Inc. recognizes the obligation to keep information about Plan Participants secure and confidential. Delta Dental does not sell information about Plan Participants to others. This notice is to help Plan Participants understand how Delta Dental may collect information, the type of information that may be collected and what information may be disclosed about Plan Participants to nonaffiliated third parties. From time to time Delta Dental may amend this privacy policy. Delta Dental maintains appropriate physical, electronic and procedural safeguards to maintain the confidentiality and security of nonpublic personal information. Access to nonpublic personal information is restricted to those who need to know the information in order to provide products or services to Plan Participants.

**A. Categories of Information Collected.** Non-public personal information from the following sources is collected and maintained:

1. Plan Participants: information Delta Dental receives on enrollment forms, change forms and other correspondence;
2. The Plan Sponsor: information received from Plan Sponsor billings, change forms and other correspondence;
3. Dental providers: information received such as dental treatments, fees for treatment, copayments collected and chart records when necessary;
4. Insurance carriers: information received for coordination of benefits or eligibility related issues;
5. Information received from a Plan Participant and/or the Plan Sponsor via the Internet.

## B. Categories of Information Disclosed and to Whom Information May Be Disclosed

Delta Dental Plan of New Mexico, Inc., will not disclose non-public personal health or financial information concerning any persons covered under the Plan to third parties not affiliated with Delta Dental, other than the Plan Sponsor except as necessary to process claims for dental services and as permitted by law.

On behalf of the Plan, Delta Dental may disclose, as permitted by law, the following kinds of non-public personal information about Plan Participants:

1. Information received from enrolled persons on applications or other forms;
2. Information about an enrolled person's transactions with Delta Dental or Delta Dental's business associates;
3. Non-public personal information about Plan Participants to the following types of third parties: dental providers, insurance companies and non-affiliated third parties as permitted or required by law.

The Plan is a "group health plan" within the meaning of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Plan Sponsor, as per the requirements of 45 CFR 164.504(f) of HIPAA, has agreed to:

1. Not use or further disclose health information protected under HIPAA ("PHI") other than as permitted or required by the Plan documents or as required by law;
2. Ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
3. Not use or disclose PHI for employment-related actions and decisions;
4. Not use or disclose PHI in connection with any other benefit or employee benefit plan;
5. Report to the Plan's designee any PHI use or disclosure that the Plan Sponsor becomes aware of that is inconsistent with the uses or disclosures provided for;
6. Make PHI available to an individual based on HIPAA's access requirements;
7. Make PHI available for amendment and incorporate any PHI amendments based on HIPAA's amendment requirements;
8. Make available the information required to provide an accounting of disclosures;
9. Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with HIPAA;
10. Ensure that adequate separation between the Plan and the Plan Sponsor is established as required by HIPAA (45 CFR 164.504(f)(2)(iii)); and
11. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction infeasible.

# VIII. DEFINITIONS

**Administrative Fee(s):** the fees from the Plan Sponsor due to Delta Dental for Plan administration.

**Administrative Services Agreement or Contract**: the Plan Sponsor Administrative Services Contract with Delta Dental, the Dental Benefit Handbook, the Summary of Benefits and, if applicable, successor agreements or renewals initially or thereafter issued or executed.

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

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

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

**Copayment**: the percentage of the dental provider's approved fee due from the Plan Participant to the dental provider.

**Deductible**: the amount a Plan Participant or family must pay toward covered services before Delta Dental makes any payment on behalf of the Plan for those covered services.

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

**Dental Necessity**: a service or supply provided by a dentist or other provider that has been determined by Delta Dental as generally accepted dental practice for the Plan Participant'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 Plan Participant or provider. The services/supplies are the most appropriate that can safely be provided. The fact that a provider has performed or prescribed a service or supply does not mean it is a dental necessity.

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

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

**Enrolled Dependent**: an eligible dependent of a Primary Plan Participant whose completed enrollment information has been received and approved for coverage.

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

1. A technology must have final approval from the appropriate regulatory governmental bodies;
2. The scientific evidence as published in peer-review literature must permit conclusions concerning the effect of the technology on health outcome;
3. The technology must improve the net health outcome;

4. The technology must be as beneficial as any established alternatives; and

5. The technology must be attainable outside the investigational settings.

**Maximum**: the highest level of the total dollars payable by Delta Dental, on behalf of the Plan, for covered dental services in a benefit period or lifetime period for each Plan Participant.

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

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

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

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

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

**Plan Participant:** an enrolled employee, enrolled dependent, COBRA-enrolled person, or other person who meets the conditions of eligibility outlined in Section I, "Eligibility and Enrollment," whose completed enrollment information has been received and approved by Delta Dental and for whom applicable administrative fees are paid.

**Plan Sponsor:** the employer or employee organization that establishes or maintains the Dental Benefit Plan.

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

**Primary Plan Participant**: an eligible employee or other person who meets the conditions of individual coverage eligibility outline in Section I, "Eligibility and Enrollment," whose completed enrollment information has been received and approved for coverage.

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

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

**Subscriber**: the Primary Plan Participant, such as an employee, who is not enrolled as a dependent.

2500 Louisiana Blvd NE Suite 600
Albuquerque, NM 87110
(505) 855-7111
1-877-395-9420
www.DeltaDentalNM.com