ORIGINAL

4582 S. Ulster Street, Suite 800
Denver, CO 80237-2567

August 19, 2010

IMA of Colorado
Attn: Pavlina Sustr
1550 17th Street, Suite 600
Denver, CO 80202

Re: City & County of Denver- Dental Renewal – Group Nos. 6026, 6791 & 6793

Dear Pavlina:

Here is the renewal information for your client, City & County of Denver, renewing on January 1, 2011. The City & County is an extremely valuable client for us. We are grateful to you for assisting in this opportunity to renew our relationship with them.

The ASC fee for 2009 and 2010 has been $3.36 pepm. Per our renewal agreement in 2009, the fee for 2011 will increase to $3.46 pepm. This fee will then be guaranteed through December 31, 2012. All of these ASC fees are net of commissions.

We value our opportunity to continue to be of service to the City and to IMA. Should you have any questions, please feel free to contact our office.

Sincerely,

Joyce Postlewait
Strategic Account Manager
720-489-4731
jpostlewait@ddpco.com

Enclosures

cc: Leslie Powers

11-137

Delta Dental PPO Plan

City & County of Denver
Group #6793 – High Option
Revised: January 1, 2011

DELTA DENTAL

Delta Dental PPO
Summary of Dental Plan Benefits
For Group #6793 – High Option
CITY AND COUNTY OF DENVER

This Summary of Dental Plan Benefits should be read in conjunction with your Employee Benefit Booklet. Your Employee Benefit Booklet will provide you with additional information about your Delta Dental plan, including information about plan exclusions and limitations. **In the event that you seek treatment from a non-participating dentist, you may have more out-of-pocket costs.**

Control Plan - Delta Dental of Colorado
Benefit Year - January 1st to December 31st

Covered Services	PPO Dentist Plan Pays	Delta Dental Premier Dentist Plan Pays	*Non-Participating Dentist Plan Pays
Diagnostic & Preventive Services			
Sealants	100%	100%	100%
Oral Exams and Cleanings	100%	100%	100%
X-Rays	100%	100%	100%
Fluoride Treatment	100%	100%	100%
Basic Services			
Simple Extractions	90%	80%	80%
Complex Oral Surgery	90%	80%	80%
Basic Restorative (Fillings)	90%	80%	80%
Endodontics (Root Canal Therapy)	90%	80%	80%
Periodontics (Gum Disease Treatment)	90%	80%	80%
Major Services			
Denture Repair/Relines/Rebases	60%	50%	50%
Prosthodontics (Dentures, Bridges)	60%	50%	50%
Special Restorative (Crowns, Inlays, Onlays)	60%	50%	50%
Occlusal Guard	60%	50%	50%
Orthodontic Services			
Orthodontics (no age limit)	50%	50%	50%
Implant Services			
Implant Services	50%	50%	50%

*** Important: Non-Participating Dentists are allowed to balance bill. Employees and/or Dependents are responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the Dentist.**

Age Type	Age Limit	Coverage Thru
Dependent Child	26	Month

Deductible (January 1st - December 31st)

Class	Type	Network	Amt
All Covered Classes Except Ortho	Individual coverage amount	Non-PPO	$25
All Covered Classes Except Ortho	Family coverage amount	Non-PPO	$75
All Covered Classes Except D&P & Ortho	Individual coverage amount	PPO	$25
All Covered Classes Except D&P & Ortho	Family coverage amount	PPO	$75

Maximum (January 1st - December 31st)

Class	Type	Network	Amt
All Covered Classes Except Ortho	Individual coverage amount	PPO and Non-PPO	$2000
Orthodontic Classes	Individual lifetime	PPO and Non-PPO	$1000
Surgical Implant Classes	Individual coverage amount	PPO and Non-PPO	$1000

Enrollment Type

The enrollment type is Open Enrollment. Open Enrollment means a period of time each Contract Year occurring prior to the Anniversary Date during which eligible Employees may choose to enroll themselves and/or their eligible Dependents in the Plan, or change from one coverage option to another if the Contract issued to the Group permits them to do so. Coverage will become effective on the Group's Anniversary Date. New hires must enroll himself or herself and any eligible dependents within 31 day of their date of employment. No other enrollment is permitted unless a qualified status change has occurred under the Health Insurance Portability and Accountability Act of 1996 and must occur within 31 days of qualified status change.

Where two Employees who are spouses and are both eligible for coverage under this contract, they may be enrolled together or separately, but not both. Dependent children may only be enrolled under one parent. The term spouse includes same gender Domestic Partner.

Under the Delta Dental PPO plan, you may visit any Dentist of your choice. There are three levels of Dentists to choose from who are located nationwide:

PPO Participating Dentist

Advantages of seeing a PPO Dentist include:

- Payment is based upon the PPO Dentist's Allowable fee, or the fee actually charged, whichever is less.
- You are only responsible for any applicable deductible and coinsurance for covered procedures.

You will receive the best benefits available on this plan by choosing a PPO Dentist.

Premier Participating Dentist (Non-PPO)

You have the option of seeing a Premier Dentist, but you may incur additional costs:

- Payment is based upon the Premier Maximum Plan Allowance, or the fee actually charged, whichever is less.
- Claim forms are submitted directly to Delta Dental by the Dentists.
- You are only responsible for any applicable deductible and coinsurance for covered procedures.

Non-Participating Dentist (Non-PPO)

You have the option of seeing a non-participating Dentist, but you may incur additional out-of-pocket costs.

- You may be responsible for payment in full to the Dentist and for filing your claim with Delta Dental for reimbursement.
- You are responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the Dentist.

COVERED AMOUNT means

- For PPO Dentists, the lesser of the PPO Dentist's Allowable fee or the fee actually charged.
- For Premier Participating Dentists, the lesser of the Premier Maximum Plan Allowance, or the fee actually charged.
- For all other Dentists, the lesser of the Non-Participating Maximum Plan Allowance, or the fee actually charged.

Colorado counties without PPO or Premier Providers are Bent, Costilla, Crowley, Gilpin, Jackson, Kiowa, Mineral, Rio Blanco, Saguache, San Juan, and Sedgwick.

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

ELIGIBILITY

All eligible employees and their dependents who enroll will be covered on the effective date. All new employees will become effective on the day eligibility has been established by the employer. Your Dependents who are covered are your lawful spouse, common law spouse, same gender Domestic Partner and your children (including the children of a same gender Domestic Partner) up to the date shown on the Summary of Dental Plan Benefits.

DEPENDENT ELIGIBILITY

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

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

TERMINATION OF COVERAGE

Coverage will terminate at the earliest of:

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

EXTENDED COVERAGE

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

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

- No benefit is payable if the Covered Service is Started after the day the Person's coverage ends.
- Benefits are payable only in the amount that would have been payable and subject to the same terms and conditions of the Contract that would have applied, if the Person's coverage was still in effect.
- Benefits are payable only if the Covered Service is Completed within 60 days after the date the Person's coverage ended.

HOW TO USE THE DELTA DENTAL PLAN

How to Find a Dentist

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

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

Integrated Voice Response (IVR): Delta Dental's IVR allows you to call and request a listing of Dentists in your area and receive it by mail or fax. Call 1-800-610-0201 and follow the prompts.

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

CLAIMS SUBMISSION

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

If you elect treatment from a non-participating Dentist, you may be responsible for filing your claim.

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

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

PRE-TREATMENT ESTIMATE

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

COVERED DENTAL SERVICES

DIAGNOSTIC, PREVENTIVE AND ADJUNCTIVE BENEFITS

Delta Dental will pay that percentage shown on the Summary of Dental Plan Benefits of the Covered Amount for the following Covered Services.

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

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

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

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

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

Limitations on Diagnostic, Preventive and Adjunctive Benefits

a) Benefits for oral examinations will not be provided more than twice in any 12-month period. Diagnosis, treatment

planning or consultation by the treating Dentist (or other person legally permitted to perform such Services by authority of license), are considered components of a complete oral examination.

b) Benefits for cleanings (adult and child), and/or any procedure that includes any component of cleaning, will not be provided more than twice in any 12-month period. For payment purposes, an adult cleaning is not a benefit for persons under age 14. For individuals with the conditions listed below, 2 additional cleanings (or any procedure that includes a component) will be provided during a 12 month period.
   - People who are diabetic and have documented periodontal (gum) conditions or;
   - Women who are pregnant and have documented periodontal (gum) conditions or;
   - People with cardiovascular disease who have documented periodontal (gum) conditions or;
   - People with kidney failure or who are undergoing dialysis and;
   - People who have an immune system which is suppressed because of chemotherapy or radiation treatment, HIV Positive status, Organ Transplant, or stem cell (bone marrow) transplant.

c) Topical fluoride application is a benefit only through age 15 and only once in 12 months.

d) Benefit for full mouth x-rays is made only after 60 months have elapsed following any prior provision of payment for full mouth x-rays under any Delta Dental plan unless documentation of special need is provided. Benefit for supplementary bitewing individual x-rays is provided once every 12 months while the patient is under any Delta Dental plan. A panoramic survey (which may include bitewing x-rays and/or periapical x-rays) is considered a full mouth x-ray. Total allowance for individual periapical x-rays, intraoral occlusal x-rays, extraoral x-rays and/or bitewing x-rays performed on the same day will not exceed the allowance for full mouth x-rays.

e) Benefit for space maintainers will only be made for appliances to maintain space for eruption of permanent back teeth in cases of premature loss of primary (deciduous) teeth through age 13.

f) Adjunctive Services related to another category of Covered Services will be paid at the same percentage as the related category of Covered Services.

g) Benefits for sealants are limited to one time per tooth in any 36 consecutive month period. Benefit is allowed only for the occlusal surface of decay-free and previously unrestored permanent molars for children through age 14. There is no separate benefit for preparation or conditioning of the tooth or any other procedure associated with the sealant application.

BASIC BENEFITS

Delta Dental will pay that percentage shown on the Summary of Dental Plan Benefits of the Covered Amount for the following Covered Services.

Basic Restorative - amalgam fillings (metal fillings) on back teeth, or resin-based composite fillings (white/plastic fillings) on front teeth and preformed shell crowns for treatment of:

- decay which results in visible destruction of hard tooth structure or
- loss of tooth structure due to fracture.

Oral Surgery - extractions and certain other surgical Services and associated covered anesthesia and/or related Covered Services.

Endodontic - certain Services for treatment of non-vital tooth pulp resulting from disease or trauma.

Periodontic - certain Services for treatment of gums and bone supporting teeth.

Limitations on Basic Benefits

a) Benefit for the same Covered Basic Restorative Service will not be provided more than once in any 12-month period.

b) Allowance for amalgam fillings (on back teeth) or resin-based composite fillings (on front teeth) may be made toward the cost of more expensive procedures or materials selected. The patient will be responsible for the portion of the Dentist's fee in excess of the Delta Dental allowance.

c) No Benefits will be provided for treatment of teeth retained in relation to an overdenture.

d) Benefit for the same Covered Surgical Periodontic Services will not be provided more than once in any 36-month period. Benefit for the same Covered Non-Surgical Periodontic Services will not be provided more than once in any 24-month period.

e) Benefit for pulpotomy/pulpectomy will be made only for primary (deciduous) teeth.

f) Periodontal maintenance procedures that include any component of cleaning are subject to the cleaning limitations outlined in Diagnostic, Preventive and Adjunctive Benefits.

g) A course of treatment for apexification/recalcification (initial, interim, and final visits) is a benefit once per tooth.

h) Allowance for assistant surgeon when determined by Delta Dental to be a Covered Service will not exceed 20% of the surgeon's fee for the same Covered Service.

MAJOR BENEFITS

Delta Dental will pay that percentage shown on the Summary of Dental Plan Benefits of the Covered Amount for the following Covered Services:

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

- decay which results in visible destruction of hard tooth structure or
- loss of tooth structure due to fracture

which cannot be restored with amalgam or resin-based composite fillings.

Other Special Restorative - buildups (which may or may not include a post) for treatment of decay which result in visible destruction of hard tooth structure or loss of tooth structure due to fracture which cannot be restored with amalgam or resin-based composite fillings.

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

Occlusal Guard: Removable dental Appliances, which are designed to minimize the effects of bruxism (grinding) and other occlusal factors.

Limitations on Major Benefits - Special Restorative and Other Special Restorative

a) When two or more similar restorations are used to restore a tooth, allowance will not exceed the Covered Amount for the most inclusive Covered Service.

b) Benefit for placement of Special Restorative Services will not be provided more than once in any 60-month period involving restorations of the same tooth. This includes any prior provision of Covered Prosthodontic Services involving the same teeth.

c) Benefit for placement of Other Special Restorative Services will not be provided more than once in any 60-month period involving restorations of the same tooth.

d) Any laboratory processed Special Restorative Service or Other Special Restorative Service (except preformed shell crowns) is not a benefit for children under the age of 12.

e) No Benefits will be provided for treatment of teeth retained in relation to an overdenture.

f) Allowance for Special Restorative Services posterior to the first molar will be limited to the allowance for a full metal restoration. The patient will be responsible for the portion of the Dentist's fee in excess of the Delta Dental allowance.

g) Allowance for inlays will be limited to the allowance for an amalgam filling on back teeth or resin-based composite on front teeth for the same number of surfaces. The patient will be responsible for the portion of the Dentist's fee in excess of the Delta Dental allowance.

h) Occlusal Guard is a covered benefit limited to once in a 36 month period.

Limitations on Major Benefits - Prosthodontic

a) Benefit for replacement of prosthodontic appliances will not be provided more than once in any 60-month period and only if documentation is provided that the appliance is unsatisfactory and cannot be made satisfactory. For removable partial dentures, the 60-month time limitation is not applicable when there is loss of an anchor tooth.

b) Benefit for placement of prosthodontic Services will not be provided more than once in any 60-month period involving restorations of the same tooth. This includes any prior benefits of Special Restorative Services involving the same teeth.

c) Allowance for cast based metal or acrylic removable partials and acrylic complete dentures may be made towards the cost of more expensive procedures or materials selected and the patient will be responsible for the portion of the Dentist's fee in excess of the Delta Dental allowance.

d) Removable temporary partial dentures are a benefit to replace missing permanent front teeth. Allowance may be made toward the cost of more expensive procedures or materials selected and the patient will be responsible for the portion of the Dentist's fee in excess of the Delta Dental allowance.

e) The surgical placement of implants is a benefit. The placement of the crown, full or partial denture, or bridge over the implant is a covered benefit once in 60 months for restorations involving the same tooth. This limitation includes any prior Special Restorative or Prosthodontic benefits for the same tooth.

f) Fixed bridges (fixed partial dentures) and/or cast metal framework partial dentures (removable partial dentures) are not a benefit for persons under age 16.

g) Fixed and removable prosthodontic appliances are not a benefit in the same arch. Allowance will be limited to the allowance for a removable appliance. Exception will be made when the fixed bridge (fixed partial denture) replaces front teeth.

h) Benefit for reline or rebase of a prosthodontic appliance will be made only once in any 36-month period. Reline or rebase of a prosthodontic appliance at the time of insertion and/or within 6 months following insertion by the same Dentist is considered a component of the appliance and separate payment will not be made for such reline or rebase. Reline or rebase of an immediate denture is a covered benefit at any time, subject to the limitation of one in 36 months.

ORTHODONTIC BENEFITS

Delta Dental will pay that percentage shown on the Summary of Dental Plan Benefits for covered orthodontics. Orthodontics are defined as the services provided by a licensed Dentist involving orthognathic surgery or appliance therapy for movement of teeth and post-treatment retention for treatment of malalignment of teeth and/or jaws including any related interceptive services. (Extraction of teeth is covered under Oral Surgery Benefits.)

Allowance will be based on total case fees to include active treatment and post treatment retention or stabilization and all payments will be on a periodic basis, in accordance with the Dentist's proposed period of active treatment. Separate benefit will not be made for post treatment stabilization.

Limitations on Orthodontic Benefits

a) No benefits will be provided for:
- Replacement or repair of appliances.
- Orthodontic care provided in the treatment of periodontal cases or cases involving treatment or repositioning of the temporomandibular joint or related conditions.

b) Periodic Orthodontic payments will end upon termination of treatment for any reason prior to completion of the case, or upon termination of the Covered Person's eligibility.

c) For an Orthodontic treatment plan started prior to the eligibility date of the patient, Delta Dental will begin periodic payments with the first payment due following the patient eligibility date. The maximum benefit will be determined based upon the prior carrier's payment history.

IMPLANT BENEFITS

Covered implants are defined as prosthetic appliances placed into or on bone of the maxilla or mandible (upper or lower jaw) to retrain or support dental prostheses and include:
- Endosseous, transosseous, subperiodsteal and endontic implants
- Implant connecting bars
- Implant repairs
- Implant removal

Benefit for replacement of an implant will be provided only if 60 months have elapsed following the prior placement of the implant. Delta Dental will pay that percentage up to the maximum amount stated on the summary page.

GENERAL LIMITATIONS - ALL SERVICES

a) Completed dental Services are Benefits when provided by a Dentist (or other person legally permitted to perform such Services by authority of license) and are determined under the standards of generally accepted dental practice to be Necessary and appropriate. Benefits will be determined (even if no monies are paid) based on the terms of the Contract and Delta Dental's Processing Guidelines.

b) Pre- and post-operative procedures are considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.

c) Local anesthesia is considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.

d) The Covered Amount for a Covered Service Started but not Completed will be limited to the amount determined by Delta Dental.

e) A temporary dental Service is considered part of any complete Covered Service. Benefits will be limited to the Covered Amount for the complete Covered Service, unless the temporary Service is specifically included as a Covered Service of this Contract.

EXCLUSIONS

The following Services are not Benefits:

a) Services for injuries or conditions which are compensable under Worker's Compensation or employer's liability laws, or Services which are provided to the Covered Person by any federal or state government agency or are provided without cost to the Covered Person by any municipality, county or other political subdivision, or any Services for which the Covered Person would have no obligation to pay in absence of this coverage, except as such exclusion may be prohibited by law.

b) Any Covered Service Started when the person was not eligible for such Service under this Contract.

c) Services for treatment of congenital (present at birth) or developmental (following birth) malformations, except intraoral dental Services for treatment of a condition which is related to or developed as a result of cleft lip and/or cleft palate, unless otherwise included as a Covered Service.

d) Services for cosmetic reasons.

e) Services for restoring tooth structure lost from wear, erosion, attrition, abrasion, or abfraction.

f) Services related to protecting, altering, correcting, stabilizing, rebuilding or maintaining teeth due to improper alignment, occlusion or contour.

g) Services related to periodontal stabilization of teeth.

h) Habit appliances athletic mouth guards and gnathological (jaw function) Services, bite registration or analysis, or any related Services.

i) Pre-medication, analgesia, hypnosis or any other patient management Services (except covered anesthetic Services).

j) Charges for prescription drugs.

k) Any Experimental or Investigational Procedures.

l) Services that may otherwise have been covered, but due to the patient's underlying condition would not prove successful to improve the oral health of the patient.

m) Any procedures done in anticipation of future need (except Covered Preventive Services).

n) Hospital costs and any additional fees charged by the Dentist or hospital for hospital services or visits, or charges for use of any facility.

o) Any anesthesia service not specifically included in Covered Services.

p) Intraoral grafts when done in areas where a tooth/teeth are not present.

q) Extraoral grafts (grafting of tissues or other substances from outside the mouth to or into oral tissues), augmentations and/or any associated appliances.

r) Orthodontic Services including any related diagnostic, preventive or interceptive Services (surgical and other treatment of malalignment of teeth and/or jaws), unless shown as covered on the Summary of Dental Plan Benefits.

s) Myofunctional therapy or speech therapy.

t) Services for the treatment of any disturbances of the temporomandibular joint (TMJ), facial pain, or any related conditions, including any related diagnostic, preventive or interceptive Services.

u) Services not performed in accordance with the laws of the State in which Services are rendered, Services performed by any person other than a person authorized by license to perform such Services, or Services performed to treat any condition, other than an oral or dental disease, malformation, abnormality or condition.

v) Oral hygiene instructions or dietary instructions.

w) Completion of forms, providing diagnostic information or records, or duplication of x-rays or other records.

x) Replacement of lost, stolen or damaged appliances.

y) Repair of appliances altered by someone other than a Dentist.

z) Any Services including any associated Services or procedures not specifically included in Covered Services.

aa) Services for which charges would not have been made if this coverage had not existed, except for Services as provided under Medicaid.

bb) Missed appointment charges.

cc) Preventive control programs, including home care items.

dd) Plaque control programs.

ee) Self-inflicted injuries.

ff) Bone grafting when done in the same site as a tooth extraction, implant, apicoectomy or hemisection.

COORDINATION OF BENEFITS

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

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

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

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

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

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

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

SUBROGATION

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

APPEAL PROCESS

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

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

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

HIPAA

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

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

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

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

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

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

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

When the qualifying event is termination of the Employee's service, COBRA coverage may be extended for a Covered Person who qualifies for Social Security disability benefits. However, the Covered Person's disability must have existed on the date of the qualifying event or began within the first 60 days of COBRA coverage. When a qualifying event occurs, the employer must give the Covered Person the necessary COBRA election form. This must be completed and returned to the employer within 60 days of the determination and before the end of the initial 18-month COBRA coverage period in order to extend COBRA coverage to 29 months.

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

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

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

GLOSSARY

ALTERNATE BENEFIT means that benefit allowed for the least costly, commonly accepted Service or supply that could be used to treat a dental problem for which there are other, more costly treatment options that the Covered Person selects.

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

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

COMPLETED means:

- For Root Canal Therapy: On the date the canals are permanently filled.
- For Fixed Bridges (fixed partial dentures), Crowns, Inlays, Onlays, and other laboratory prepared restorations: On the date the restoration is cemented in place.
- For Dentures and Partial Dentures (removable partial dentures): On the date that the final appliance is first inserted in the mouth.
- For all other Services, on the date the procedure is Started.

For benefit payment purposes, the date Completed will be considered as the date when a Covered Service is incurred.

DEDUCTIBLE means the portion of the Covered Amount for certain Covered Services which must be paid in full for each Covered Person before any Benefits are payable. The amount of the Deductible is shown on the Summary of Dental Plan Benefits. If there is a maximum amount that a family must pay in Deductibles that will also be shown on the Summary of Dental Plan Benefits.

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

DEPENDENT means

- the Employee's lawful spouse, including common law spouse or same gender Domestic Partner;
- a child under the Dependent Age Limit shown on the Summary of Dental Plan Benefits;
- a child who reaches the Dependent Age Limit stated on the Summary of Dental Plan Benefits, is incapable of self-support because of physical handicap or mental incapacity that began before reaching the Dependent Age Limit, and is dependent on the Employee. Delta Dental may annually request a copy of the court-ordered guardianship as proof of such handicap or incapacity and dependency. Upon failure to submit such required proof, or when the child is no longer incapacitated, coverage will terminate.

  Eligible Dependent children include natural children, stepchildren, court-ordered guardianship, adopted children and foster children.

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

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

DOMESTIC PARTNER means

- must be of the same gender
- is 18 years of age or older
- is mentally competent to consent to contract
- has an exclusive, committed relationship with the Employee with the intent for the relationship to last indefinitely
- shares basic living expenses with the Employee
- is unmarried, and
- is not related by blood to the Employee such as a parent, brother, sister, half brother or sister, niece, nephew, aunt, uncle, grandparent or grandchild.

You and your same gender Domestic Partner must complete an affidavit of Domestic Partnership confirming the following information:

- The partners have an exclusive, committed relationship and hold yourselves out as committed partners
- Both partners share basic living expenses with the intent for the relationship to last indefinitely
- Are both 18 years of age or older
- Neither partner is married
- Neither partner is related by blood to the other as described above, and
- Neither partner has had a different domestic partner within 6 months of filing with the employer a statement of termination of domestic partnership

EMPLOYEE means someone who works at a minimum number of hours as defined by the employer.

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

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

MAXIMUM PLAN ALLOWANCE means the maximum allowable amount as determined by Delta Dental for a procedure.

STARTED means

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

NOTICE OF PRIVACY PRACTICES

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

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

How We May Use and Disclose Health Information About You

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Rights Regarding Health Information About You

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

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

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

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

Your Right to Request Restrictions on Uses and Disclosures: Although you have this right, Delta Dental is not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing.

Your Right to Request Confidential Communications Through a Reasonable Alternative Means or at an Alternative Location: To request confidential communications, you must submit your request in writing. We are not required to agree to your request, unless such disclosure could cause you to be in danger.

Your Right to a Paper Copy of this Notice: You may obtain additional paper copies of this Notice by sending us a written request. You may also obtain a copy of this Notice at our website www.deltadentalco.com.

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

Changes to this Notice

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

Send Written Requests Regarding this Privacy Notice to:

Privacy Officer
PO Box 5468
Denver CO 80217-5468

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

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

Delta Dental of Colorado
4582 South Ulster Street, Suite 800
Denver, CO 80237

Customer Service:
1-800-610-0201

1/11

Delta Dental PPO Plan

City & County of Denver
Group #6026 – Low Option
Revised: January 1, 2011

DELTA DENTAL

Delta Dental PPO
Summary of Dental Plan Benefits
For Group #6026 – Low Option
CITY AND COUNTY OF DENVER

This Summary of Dental Plan Benefits should be read in conjunction with your Employee Benefit Booklet. Your Employee Benefit Booklet will provide you with additional information about your Delta Dental plan, including information about plan exclusions and limitations. **In the event that you seek treatment from a non-participating dentist, you may have more out-of-pocket costs.**

Control Plan - Delta Dental of Colorado
Benefit Year - January 1st to December 31st

Covered Services	PPO Dentist Plan Pays	Delta Dental Premier Dentist Plan Pays	*Non-Participating Dentist Plan Pays
Diagnostic & Preventive Services			
Sealants	100%	80%	80%
Oral Exams and Cleanings	100%	80%	80%
X-Rays	100%	80%	80%
Fluoride Treatment	100%	80%	80%
Basic Services			
Simple Extractions	80%	50%	50%
Complex Oral Surgery	80%	50%	50%
Basic Restorative (Fillings)	80%	50%	50%
Endodontics (Root Canal Therapy)	80%	50%	50%
Periodontics (Gum Disease Treatment)	80%	50%	50%
Major Services			
Denture Repair/Relines/Rebases	50%	50%	50%
Prosthodontics (Dentures, Bridges)	50%	50%	50%
Special Restorative (Crowns, Inlays, Onlays)	50%	50%	50%
Occlusal Guard	50%	50%	50%
Orthodontic Services			
Orthodontics (no age limit)	50%	50%	50%
Implant Services			
Implant Services	50%	50%	50%

*** Important: Non-Participating Dentists are allowed to balance bill. Employees and/or Dependents are responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the Dentist.**

Age

Type	Age Limit	Coverage Thru
Dependent Child	26	Month

Deductible (January 1st - December 31st)

Class	Type	Network	Amt
All Covered Classes Except Ortho	Individual coverage amount	Non-PPO	$25
All Covered Classes Except Ortho	Family coverage amount	Non-PPO	$75
All Covered Classes Except D&P & Ortho	Individual coverage amount	PPO	$25
All Covered Classes Except D&P & Ortho	Family coverage amount	PPO	$75

Maximum (January 1st - December 31st)

Class	Type	Network	Amt
All Covered Classes Except Ortho	Individual coverage amount	PPO and Non-PPO	$1250
Orthodontic Classes	Individual lifetime	PPO and Non-PPO	$1000
Surgical Implant Classes	Individual coverage amount	PPO and Non-PPO	$1000

Enrollment Type

The enrollment type is Open Enrollment. Open Enrollment means a period of time each Contract Year occurring prior to the Anniversary Date during which eligible Employees may choose to enroll themselves and/or their eligible Dependents in the Plan, or change from one coverage option to another if the Contract issued to the Group permits them to do so. Coverage will become effective on the Group's Anniversary Date. New hires must enroll himself or herself and any eligible dependents within 31 day of their date of employment. No other enrollment is permitted unless a qualified status change has occurred under the Health Insurance Portability and Accountability Act of 1996 and must occur within 31 days of qualified status change.

Where two Employees who are spouses and are both eligible for coverage under this contract, they may be enrolled together or separately, but not both. Dependent children may only be enrolled under one parent. The term spouse includes same gender Domestic Partner.

Under the Delta Dental PPO plan, you may visit any Dentist of your choice. There are three levels of Dentists to choose from who are located nationwide:

PPO Participating Dentist

Advantages of seeing a PPO Dentist include:

- Payment is based upon the PPO Dentist's Allowable fee, or the fee actually charged, whichever is less.
- You are only responsible for any applicable deductible and coinsurance for covered procedures.

You will receive the best benefits available on this plan by choosing a PPO Dentist.

Premier Participating Dentist (Non-PPO)

You have the option of seeing a Premier Dentist, but you may incur additional costs:

- Payment is based upon the Premier Maximum Plan Allowance, or the fee actually charged, whichever is less.
- Claim forms are submitted directly to Delta Dental by the Dentists.
- You are only responsible for any applicable deductible and coinsurance for covered procedures.

Non-Participating Dentist (Non-PPO)

You have the option of seeing a non-participating Dentist, but you may incur additional out-of-pocket costs.

- You may be responsible for payment in full to the Dentist and for filing your claim with Delta Dental for reimbursement.
- You are responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the Dentist.

COVERED AMOUNT means

- For PPO Dentists, the lesser of the PPO Dentist's Allowable fee or the fee actually charged.
- For Premier Participating Dentists, the lesser of the Premier Maximum Plan Allowance, or the fee actually charged.
- For all other Dentists, the lesser of the Non-Participating Maximum Plan Allowance, or the fee actually charged.

Colorado counties without PPO or Premier Providers are Bent, Costilla, Crowley, Gilpin, Jackson, Kiowa, Mineral, Rio Blanco, Saguache, San Juan, and Sedgwick.

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

ELIGIBILITY

All eligible employees and their dependents who enroll will be covered on the effective date. All new employees will become effective on the day eligibility has been established by the employer. Your Dependents who are covered are your lawful spouse, common law spouse, same gender Domestic Partner and your children (including the children of a same gender Domestic Partner) up to the date shown on the Summary of Dental Plan Benefits.

DEPENDENT ELIGIBILITY

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

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

TERMINATION OF COVERAGE

Coverage will terminate at the earliest of:

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

EXTENDED COVERAGE

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

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

- No benefit is payable if the Covered Service is Started after the day the Person's coverage ends.
- Benefits are payable only in the amount that would have been payable and subject to the same terms and conditions of the Contract that would have applied, if the Person's coverage was still in effect.
- Benefits are payable only if the Covered Service is Completed within 60 days after the date the Person's coverage ended.

HOW TO USE THE DELTA DENTAL PLAN

How to Find a Dentist

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

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

Integrated Voice Response (IVR): Delta Dental's IVR allows you to call and request a listing of Dentists in your area and receive it by mail or fax. Call 1-800-610-0201 and follow the prompts.

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

CLAIMS SUBMISSION

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

If you elect treatment from a non-participating Dentist, you may be responsible for filing your claim.

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

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

PRE-TREATMENT ESTIMATE

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

COVERED DENTAL SERVICES

DIAGNOSTIC, PREVENTIVE AND ADJUNCTIVE BENEFITS

Delta Dental will pay that percentage shown on the Summary of Dental Plan Benefits of the Covered Amount for the following Covered Services.

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

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

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

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

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

Limitations on Diagnostic, Preventive and Adjunctive Benefits

a) Benefits for oral examinations will not be provided more than twice in any 12-month period. Diagnosis, treatment

planning or consultation by the treating Dentist (or other person legally permitted to perform such Services by authority of license), are considered components of a complete oral examination.

b) Benefits for cleanings (adult and child), and/or any procedure that includes any component of cleaning, will not be provided more than twice in any 12-month period. For payment purposes, an adult cleaning is not a benefit for persons under age 14. For individuals with the conditions listed below, 2 additional cleanings (or any procedure that includes a component) will be provided during a 12 month period.
   - People who are diabetic and have documented periodontal (gum) conditions or;
   - Women who are pregnant and have documented periodontal (gum) conditions or;
   - People with cardiovascular disease who have documented periodontal (gum) conditions or;
   - People with kidney failure or who are undergoing dialysis and;
   - People who have an immune system which is suppressed because of chemotherapy or radiation treatment, HIV Positive status, Organ Transplant, or stem cell (bone marrow) transplant.

c) Topical fluoride application is a benefit only through age 15 and only once in 12 months.

d) Benefit for full mouth x-rays is made only after 60 months have elapsed following any prior provision of payment for full mouth x-rays under any Delta Dental plan unless documentation of special need is provided. Benefit for supplementary bitewing individual x-rays is provided once every 12 months while the patient is under any Delta Dental plan. A panoramic survey (which may include bitewing x-rays and/or periapical x-rays) is considered a full mouth x-ray. Total allowance for individual periapical x-rays, intraoral occlusal x-rays, extraoral x-rays and/or bitewing x-rays performed on the same day will not exceed the allowance for full mouth x-rays.

e) Benefit for space maintainers will only be made for appliances to maintain space for eruption of permanent back teeth in cases of premature loss of primary (deciduous) teeth through age 13.

f) Adjunctive Services related to another category of Covered Services will be paid at the same percentage as the related category of Covered Services.

g) Benefits for sealants are limited to one time per tooth in any 36 consecutive month period. Benefit is allowed only for the occlusal surface of decay-free and previously unrestored permanent molars for children through age 14. There is no separate benefit for preparation or conditioning of the tooth or any other procedure associated with the sealant application.

BASIC BENEFITS

Delta Dental will pay that percentage shown on the Summary of Dental Plan Benefits of the Covered Amount for the following Covered Services.

Basic Restorative - amalgam fillings (metal fillings) on back teeth, or resin-based composite fillings (white/plastic fillings) on front teeth and preformed shell crowns for treatment of:

- decay which results in visible destruction of hard tooth structure or
- loss of tooth structure due to fracture.

Oral Surgery - extractions and certain other surgical Services and associated covered anesthesia and/or related Covered Services.

Endodontic - certain Services for treatment of non-vital tooth pulp resulting from disease or trauma.

Periodontic - certain Services for treatment of gums and bone supporting teeth.

Limitations on Basic Benefits

a) Benefit for the same Covered Basic Restorative Service will not be provided more than once in any 12-month period.

b) Allowance for amalgam fillings (on back teeth) or resin-based composite fillings (on front teeth) may be made toward the cost of more expensive procedures or materials selected. The patient will be responsible for the portion of the Dentist's fee in excess of the Delta Dental allowance.

c) No Benefits will be provided for treatment of teeth retained in relation to an overdenture.

d) Benefit for the same Covered Surgical Periodontic Services will not be provided more than once in any 36-month period. Benefit for the same Covered Non-Surgical Periodontic Services will not be provided more than once in any 24-month period.

e) Benefit for pulpotomy/pulpectomy will be made only for primary (deciduous) teeth.

f) Periodontal maintenance procedures that include any component of cleaning are subject to the cleaning limitations outlined in Diagnostic, Preventive and Adjunctive Benefits.

g) A course of treatment for apexification/recalcification (initial, interim, and final visits) is a benefit once per tooth.

h) Allowance for assistant surgeon when determined by Delta Dental to be a Covered Service will not exceed 20% of the surgeon's fee for the same Covered Service.

MAJOR BENEFITS

Delta Dental will pay that percentage shown on the Summary of Dental Plan Benefits of the Covered Amount for the following Covered Services:

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

- decay which results in visible destruction of hard tooth structure or
- loss of tooth structure due to fracture

which cannot be restored with amalgam or resin-based composite fillings.

Other Special Restorative - buildups (which may or may not include a post) for treatment of decay which result in visible destruction of hard tooth structure or loss of tooth structure due to fracture which cannot be restored with amalgam or resin-based composite fillings.

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

Occlusal Guard: Removable dental appliances, which are designed to minimize the effects of bruxism (grinding) and other occlusal factors.

Limitations on Major Benefits - Special Restorative and Other Special Restorative

a) When two or more similar restorations are used to restore a tooth, allowance will not exceed the Covered Amount for the most inclusive Covered Service.

b) Benefit for placement of Special Restorative Services will not be provided more than once in any 60-month period involving restorations of the same tooth. This includes any prior provision of Covered Prosthodontic Services involving the same teeth.

c) Benefit for placement of Other Special Restorative Services will not be provided more than once in any 60-month period involving restorations of the same tooth.

d) Any laboratory processed Special Restorative Service or Other Special Restorative Service (except preformed shell crowns) is not a benefit for children under the age of 12.

e) No Benefits will be provided for treatment of teeth retained in relation to an overdenture.

f) Allowance for Special Restorative Services posterior to the first molar will be limited to the allowance for a full metal restoration. The patient will be responsible for the portion of the Dentist's fee in excess of the Delta Dental allowance.

g) Allowance for inlays will be limited to the allowance for an amalgam filling on back teeth or resin-based composite on front teeth for the same number of surfaces. The patient will be responsible for the portion of the Dentist's fee in excess of the Delta Dental allowance.

h) Occlusal Guard is a covered benefit limited to once in a 36 month period.

Limitations on Major Benefits - Prosthodontic

a) Benefit for replacement of prosthodontic appliances will not be provided more than once in any 60-month period and only if documentation is provided that the appliance is unsatisfactory and cannot be made satisfactory. For removable partial dentures, the 60-month time limitation is not applicable when there is loss of an anchor tooth.

b) Benefit for placement of prosthodontic Services will not be provided more than once in any 60-month period involving restorations of the same tooth. This includes any prior benefits of Special Restorative Services involving the same teeth.

c) Allowance for cast based metal or acrylic removable partials and acrylic complete dentures may be made towards the cost of more expensive procedures or materials selected and the patient will be responsible for the portion of the Dentist's fee in excess of the Delta Dental allowance.

d) Removable temporary partial dentures are a benefit to replace missing permanent front teeth. Allowance may be made toward the cost of more expensive procedures or materials selected and the patient will be responsible for the portion of the Dentist's fee in excess of the Delta Dental allowance.

e) The surgical placement of implants is a benefit. The placement of the crown, full or partial denture, or bridge over the implant is a covered benefit once in 60 months for restorations involving the same tooth. This limitation includes any prior Special Restorative or Prosthodontic benefits for the same tooth.

f) Fixed bridges (fixed partial dentures) and/or cast metal framework partial dentures (removable partial dentures) are not a benefit for persons under age 16.

g) Fixed and removable prosthodontic appliances are not a benefit in the same arch. Allowance will be limited to the allowance for a removable appliance. Exception will be made when the fixed bridge (fixed partial denture) replaces front teeth.

h) Benefit for reline or rebase of a prosthodontic appliance will be made only once in any 36-month period. Reline or rebase of a prosthodontic appliance at the time of insertion and/or within 6 months following insertion by the same Dentist is considered a component of the appliance and separate payment will not be made for such reline or rebase. Reline or rebase of an immediate denture is a covered benefit at any time, subject to the limitation of one in 36 months.

ORTHODONTIC BENEFITS

Delta Dental will pay that percentage shown on the Summary of Dental Plan Benefits for covered orthodontics. Orthodontics are defined as the services provided by a licensed Dentist involving orthognathic surgery or appliance therapy for movement of teeth and post-treatment retention for treatment of malalignment of teeth and/or jaws including any related interceptive services. (Extraction of teeth is covered under Oral Surgery Benefits.)

Allowance will be based on total case fees to include active treatment and post treatment retention or stabilization and all payments will be on a periodic basis, in accordance with the Dentist's proposed period of active treatment. Separate benefit will not be made for post treatment stabilization.

Limitations on Orthodontic Benefits

a) No benefits will be provided for:
- Replacement or repair of appliances.
- Orthodontic care provided in the treatment of periodontal cases or cases involving treatment or repositioning of the temporomandibular joint or related conditions.

b) Periodic Orthodontic payments will end upon termination of treatment for any reason prior to completion of the case, or upon termination of the Covered Person's eligibility.

c) For an Orthodontic treatment plan started prior to the eligibility date of the patient, Delta Dental will begin periodic payments with the first payment due following the patient eligibility date. The maximum benefit will be determined based upon the prior carrier's payment history.

IMPLANT BENEFITS

Covered implants are defined as prosthetic appliances placed into or on bone of the maxilla or mandible (upper or lower jaw) to retrain or support dental prostheses and include:

- Endosseous, transosseous, subperiodsteal and endontic implants
- Implant connecting bars
- Implant repairs
- Implant removal

Benefit for replacement of an implant will be provided only if 60 months have elapsed following the prior placement of the implant. Delta Dental will pay that percentage up to the maximum amount stated on the summary page.

GENERAL LIMITATIONS - ALL SERVICES

a) Completed dental Services are Benefits when provided by a Dentist (or other person legally permitted to perform such Services by authority of license) and are determined under the standards of generally accepted dental practice to be Necessary and appropriate. Benefits will be determined (even if no monies are paid) based on the terms of the Contract and Delta Dental's Processing Guidelines.

b) Pre- and post-operative procedures are considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.

c) Local anesthesia is considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.

d) The Covered Amount for a Covered Service Started but not Completed will be limited to the amount determined by Delta Dental.

e) A temporary dental Service is considered part of any complete Covered Service. Benefits will be limited to the Covered Amount for the complete Covered Service, unless the temporary Service is specifically included as a Covered Service of this Contract.

EXCLUSIONS

The following Services are not Benefits:

a) Services for injuries or conditions which are compensable under Worker's Compensation or employer's liability laws, or Services which are provided to the Covered Person by any federal or state government agency or are provided without cost to the Covered Person by any municipality, county or other political subdivision, or any Services for which the Covered Person would have no obligation to pay in absence of this coverage, except as such exclusion may be prohibited by law.

b) Any Covered Service Started when the person was not eligible for such Service under this Contract.

c) Services for treatment of congenital (present at birth) or developmental (following birth) malformations, except intraoral dental Services for treatment of a condition which is related to or developed as a result of cleft lip and/or cleft palate, unless otherwise included as a Covered Service.

d) Services for cosmetic reasons.

e) Services for restoring tooth structure lost from wear, erosion, attrition, abrasion, or abfraction.

f) Services related to protecting, altering, correcting, stabilizing, rebuilding or maintaining teeth due to improper alignment, occlusion or contour.

g) Services related to periodontal stabilization of teeth.

h) Habit appliances, athletic mouth guards and gnathological (jaw function) Services, bite registration or analysis, or any related Services.

i) Pre-medication, analgesia, hypnosis or any other patient management Services (except covered anesthetic Services).

j) Charges for prescription drugs.

k) Any Experimental or Investigational Procedures.

l) Services that may otherwise have been covered, but due to the patient's underlying condition would not prove successful to improve the oral health of the patient.

m) Any procedures done in anticipation of future need (except Covered Preventive Services).

n) Hospital costs and any additional fees charged by the Dentist or hospital for hospital services or visits, or charges for use of any facility.

o) Any anesthesia service not specifically included in Covered Services.

p) Intraoral grafts when done in areas where a tooth/teeth are not present.

q) Extraoral grafts (grafting of tissues or other substances from outside the mouth to or into oral tissues), augmentations and/or any associated appliances.

r) Orthodontic Services including any related diagnostic, preventive or interceptive Services (surgical and other treatment of malalignment of teeth and/or jaws), unless shown as covered on the Summary of Dental Plan Benefits.

s) Myofunctional therapy or speech therapy.

t) Services for the treatment of any disturbances of the temporomandibular joint (TMJ), facial pain, or any related conditions, including any related diagnostic, preventive or interceptive Services.

u) Services not performed in accordance with the laws of the State in which Services are rendered, Services performed by any person other than a person authorized by license to perform such Services, or Services performed to treat any condition, other than an oral or dental disease, malformation, abnormality or condition.

v) Oral hygiene instructions or dietary instructions.

w) Completion of forms, providing diagnostic information or records, or duplication of x-rays or other records.

x) Replacement of lost, stolen or damaged appliances.

y) Repair of appliances altered by someone other than a Dentist.

z) Any Services including any associated Services or procedures not specifically included in Covered Services.

aa) Services for which charges would not have been made if this coverage had not existed, except for Services as provided under Medicaid.

bb) Missed appointment charges.

cc) Preventive control programs, including home care items.

dd) Plaque control programs.

ee) Self-inflicted injuries.

ff) Bone grafting when done in the same site as a tooth extraction, implant, apicoectomy or hemisection.

COORDINATION OF BENEFITS

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

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

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

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

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

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

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

SUBROGATION

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

APPEAL PROCESS

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

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

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

HIPAA

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

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

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

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

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

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

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

When the qualifying event is termination of the Employee's service, COBRA coverage may be extended for a Covered Person who qualifies for Social Security disability benefits. However, the Covered Person's disability must have existed on the date of the qualifying event or began within the first 60 days of COBRA coverage. When a qualifying event occurs, the employer must give the Covered Person the necessary COBRA election form. This must be completed and returned to the employer within 60 days of the determination and before the end of the initial 18-month COBRA coverage period in order to extend COBRA coverage to 29 months.

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

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

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

GLOSSARY

ALTERNATE BENEFIT means that benefit allowed for the least costly, commonly accepted Service or supply that could be used to treat a dental problem for which there are other, more costly treatment options that the Covered Person selects.

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

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

COMPLETED means:

- For Root Canal Therapy: On the date the canals are permanently filled.
- For Fixed Bridges (fixed partial dentures), Crowns, Inlays, Onlays, and other laboratory prepared restorations: On the date the restoration is cemented in place.
- For Dentures and Partial Dentures (removable partial dentures): On the date that the final appliance is first inserted in the mouth.
- For all other Services, on the date the procedure is Started.

For benefit payment purposes, the date Completed will be considered as the date when a Covered Service is incurred.

DEDUCTIBLE means the portion of the Covered Amount for certain Covered Services which must be paid in full for each Covered Person before any Benefits are payable. The amount of the Deductible is shown on the Summary of Dental Plan Benefits. If there is a maximum amount that a family must pay in Deductibles that will also be shown on the Summary of Dental Plan Benefits.

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

DEPENDENT means

- the Employee's lawful spouse, including common law spouse or same gender Domestic Partner;
- a child under the Dependent Age Limit shown on the Summary of Dental Plan Benefits;
- a child who reaches the Dependent Age Limit stated on the Summary of Dental Plan Benefits, is incapable of self-support because of physical handicap or mental incapacity that began before reaching the Dependent Age Limit, and is dependent on the Employee. Delta Dental may annually request a copy of the court-ordered guardianship as proof of such handicap or incapacity and dependency. Upon failure to submit such required proof, or when the child is no longer incapacitated, coverage will terminate.

  Eligible Dependent children include natural children, stepchildren, court-ordered guardianship, adopted children and foster children.

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

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

DOMESTIC PARTNER means

- must be of the same gender
- is 18 years of age or older
- is mentally competent to consent to contract
- has an exclusive, committed relationship with the Employee with the intent for the relationship to last indefinitely
- shares basic living expenses with the Employee
- is unmarried, and
- is not related by blood to the Employee such as a parent, brother, sister, half brother or sister, niece, nephew, aunt, uncle, grandparent or grandchild.

You and your same gender Domestic Partner must complete an affidavit of Domestic Partnership confirming the following information:

- The partners have an exclusive, committed relationship and hold yourselves out as committed partners
- Both partners share basic living expenses with the intent for the relationship to last indefinitely
- Are both 18 years of age or older
- Neither partner is married
- Neither partner is related by blood to the other as described above, and
- Neither partner has had a different domestic partner within 6 months of filing with the employer a statement of termination of domestic partnership

EMPLOYEE means someone who works at a minimum number of hours as defined by the employer.

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

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

MAXIMUM PLAN ALLOWANCE means the maximum allowable amount as determined by Delta Dental for a procedure.

STARTED means

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

NOTICE OF PRIVACY PRACTICES

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

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

How We May Use and Disclose Health Information About You

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Rights Regarding Health Information About You

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

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

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

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

Your Right to Request Restrictions on Uses and Disclosures: Although you have this right, Delta Dental is not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing.

Your Right to Request Confidential Communications Through a Reasonable Alternative Means or at an Alternative Location: To request confidential communications, you must submit your request in writing. We are not required to agree to your request, unless such disclosure could cause you to be in danger.

Your Right to a Paper Copy of this Notice: You may obtain additional paper copies of this Notice by sending us a written request. You may also obtain a copy of this Notice at our website www.deltadentalco.com.

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

Changes to this Notice

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

Send Written Requests Regarding this Privacy Notice to:

Privacy Officer
PO Box 5468
Denver CO 80217-5468

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

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

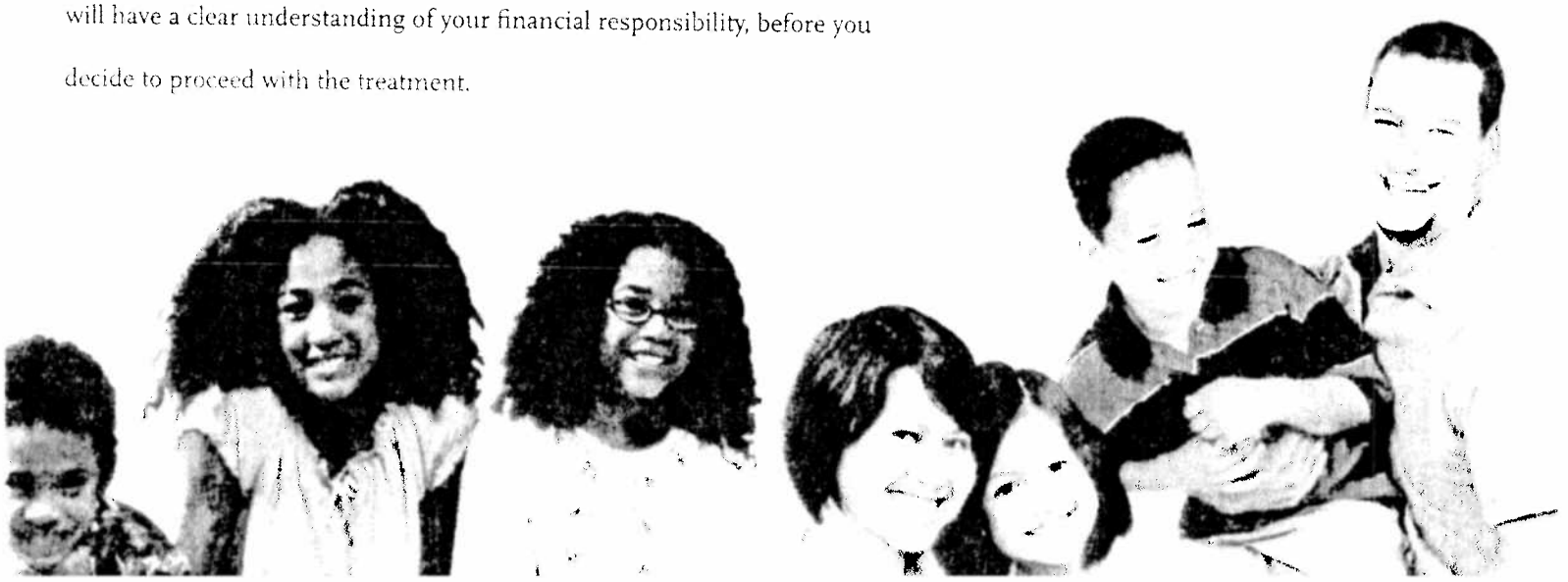
Delta Dental of Colorado
4582 South Ulster Street, Suite 800
Denver, CO 80237

Customer Service:
1-800-610-0201

You have an EPO dental plan – EPO is a feature of the Delta Dental PPO℠ product. This plan is different from standard dental plans because it provides benefits only if you visit a Delta Dental PPO dentist. If you receive treatment from a non-PPO dentist, you will not receive benefits. You will be responsible for all fees charged by the non-PPO dentist. Bottom line: you need to see a PPO dentist in order to receive benefits. The good news is, with over 1,400 PPO dentists in Colorado, you have many options.

- PPO dentists submit claim forms directly to Delta Dental.
- You pay only your portion for covered services (you do not have to pay the entire amount and wait to be reimbursed).
- Non-covered services are billed to you at Delta Dental's discount rate, meaning you still save money even if the procedure is not covered under your plan.

It makes sense to find out how much your portion of expensive procedures will be, by asking your dentist to submit a pre-treatment estimate. Delta Dental will review your dentist's treatment plan and tell you exactly how much of the bill will be your responsibility. This way, you will have a clear understanding of your financial responsibility, before you decide to proceed with the treatment.



Delta Dental of Colorado
EXCLUSIVE PANEL OPTION (EPO)
Schedule EPO 1B
List of Patient Co-Payments

* See Special Provisions on Last Page

Proc Code	Procedure Code Definition	Patient Co-Pay
DIAGNOSTIC CODES		
D0120	Periodic oral evaluation	$10.00
D0140	Limited oral evaluation - problem focused	$10.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$10.00
D0150	Comprehensive oral evaluation - new or established patient	$10.00
D0160	Detailed and extensive oral evaluation-problem focused, by report	$10.00
D0180	Comprehensive periodontal evaluation - new or established patient	$10.00
D0210	Intraoral-complete series (including bitewings)	$0.00
D0220	Intraoral-periapical-first film	$0.00
D0230	Intraoral-periapical-each additional film	$0.00
D0240	Intraoral-occlusal film	$0.00
D0270	Bitewing-single film	$0.00
D0272	Bitewings-two films	$0.00
D0273	Bitewings-three films	$0.00
D0274	Bitewings-four films	$0.00
D0277	Vertical bitewings-7 to 8 films	$0.00
D0330	Panoramic film	$0.00
D0460	Pulp vitality tests	$0.00
PREVENTIVE CODES		
D1110	Prophylaxis-adult	$0.00
D1120	Prophylaxis-child	$0.00
D1203	Topical application of fluoride (prophylaxis not included)-child	$0.00
D1206	Topical Fluoride Varnish - therapeutic application for moderate to high caries risk patients	$0.00
D1351	Sealant-per tooth	$0.00
D1510	Space maintainer-fixed-unilateral	$0.00
D1515	Space maintainer-fixed-bilateral	$0.00
D1520	Space maintainer-removable-unilateral	$0.00
D1525	Space maintainer-removable-bilateral	$0.00
BASIC SERVICES (Restorative Codes)		
D2140	Amalgam-one surface, primary or permanent	$21.00
D2150	Amalgam-two surfaces, primary or permanent	$28.00
D2160	Amalgam-three surfaces, primary or permanent	$33.00
D2161	Amalgam-four or more surfaces, primary or permanent	$40.00
D2330	Resin-based composite-one surface, anterior	$24.00
D2331	Resin-based composite-two surfaces, anterior	$32.00
D2332	Resin-based composite-three surfaces, anterior	$38.00
D2335	Resin-based composite-four or more surfaces or involving incisal angle (anterior)	$46.00
D2391	Resin-based composite-one surface, posterior	$29.00
D2392	Resin-based composite-two surfaces, posterior	$44.00
D2393	Resin-based composite-three surfaces, posterior	$62.00

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D2394	Resin-based composite-four or more surfaces, posterior	$73.00
D2520	Inlay-metallic-two surfaces	$193.00
D2530	Inlay-metallic-three or more surfaces	$223.00
D2543	Onlay-metallic-three surfaces	$233.00
D2544	Onlay-metallic-four or more surfaces	$237.00
D2710	Crown-resin-based composite (indirect)	$161.00
D2740	Crown-porcelain/ceramic substrate	$295.00
D2750	Crown-porcelain fused to high noble metal	$284.00
D2751	Crown-porcelain fused to predominantly base metal	$245.00
D2752	Crown-porcelain fused to noble metal	$275.00
D2780	Crown-3/4 cast high noble metal	$273.00
D2781	Crown-3/4 cast predominantly base metal	$238.00
D2782	Crown-3/4 cast noble metal	$268.00
D2790	Crown-full cast high noble metal	$287.00
D2791	Crown-full cast predominantly base metal	$244.00
D2792	Crown-full cast noble metal	$280.00
D2910	Recement inlay, onlay or partial coverage restoration	$13.00
D2920	Recement crown	$15.00
D2930	Prefabricated stainless steel crown-primary tooth	$45.00
D2931	Prefabricated stainless steel crown-permanent tooth	$49.00
D2932	Prefabricated resin crown	$48.00
D2933	Prefabricated stainless steel crown with resin window	$61.00
D2940	Sedative filling	$16.00
D2950	Core buildup, including any pins	$43.00
D2951	Pin retention-per tooth, in addition to restoration	$10.00
D2952	Cast post and core in addition to crown	$59.00
D2953	Each additional cast post - same tooth	$0.00
D2954	Prefabricated post and core in addition to crown	$51.00
D2957	Each additional prefabricated post - same tooth	$0.00
D2961	Labial veneer (resin laminate)-laboratory	$139.00
D2962	Labial veneer (porcelain laminate)-laboratory	$147.00
BASIC SERVICES (Endodontic Codes)		
D3110	Pulp cap-direct (excluding final restoration)	$10.00
D3220	Therapeutic pulpotomy (excluding final restoration)	$26.00
D3310	Anterior (excluding final restoration)	$110.00
D3320	Bicuspid (excluding final restoration)	$129.00
D3330	Molar (excluding final restoration)	$172.00
D3346	Retreatment of previous root canal therapy-anterior	$191.00
D3347	Retreatment of previous root canal therapy-bicuspid	$225.00
D3348	Retreatment of previous root canal therapy-molar	$297.00
D3410	Apicoectomy/periradicular surgery-anterior	$114.00
D3421	Apicoectomy/periradicular surgery-bicuspid (first root)	$126.00

Delta Dental of Colorado
EXCLUSIVE PANEL OPTION (EPO)
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Proc Code	Procedure Code Definition	Patient Co-Pay
D3425	Apicoectomy/periradicular surgery-molar (first root)	$150.00
D3426	Apicoectomy/periradicular surgery (each additional root)	$41.00
D3430	Retrograde filling-per root	$34.00
D3450	Root amputation - per root	$80.00
BASIC SERVICES (Periodontic Codes)		
D4210	Gingivectomy or gingivoplasty-four or more contiguous teeth or bounded teeth spaces per	$70.00
D4211	Gingivectomy or gingivoplasty-one to three contiguous teeth or bounded teeth spaces per	$26.00
D4240	Gingival flap procedure, including root planing-four or more contiguous teeth or bounded	$112.00
D4241	Gingival flap procedure, including root planing-one to three contiguous teeth or bounded	$67.00
D4260	Osseous surgery (including flap entry and closure)-four or more contiguous teeth or	$284.00
D4261	Osseous surgery (including flap entry and closure)-one to three contiguous teeth or	$170.00
D4263	Bone replacement graft-first site in quadrant	$71.00
D4264	Bone replacement graft-each additional site in quadrant	$47.00
D4271	Free soft tissue graft procedure (including donor site surgery)	$124.00
D4341	Periodontal scaling and root planing-four or more teeth per quadrant	$39.00
D4342	Periodontal scaling and root planing-one to three teeth, per quadrant	$23.00
D4910	Periodontal maintenance	$24.00
MAJOR SERVICES (Prosthodontic Codes - Removable)		
D5110	Complete denture, maxillary	$349.00
D5120	Complete denture, mandibular	$349.00
D5130	Immediate denture, maxillary	$377.00
D5140	Immediate denture, mandibular	$377.00
D5211	Maxillary partial denture-resin base (including any conventional clasps, rests and teeth)	$243.00
D5212	Mandibular partial denture-resin base (including any conventional clasps, rests and teeth)	$243.00
D5213	Maxillary partial denture-cast metal framework with resin denture bases (including any	$364.00
D5214	Mandibular partial denture-cast metal framework with resin denture bases (including any	$364.00
D5410	Adjust complete denture, maxillary	$17.00
D5411	Adjust complete denture, mandibular	$17.00
D5421	Adjust partial denture, maxillary	$16.00
D5422	Adjust partial denture, mandibular	$16.00
D5510	Repair broken complete denture base	$40.00

Delta Dental of Colorado
EXCLUSIVE PANEL OPTION (EPO)
Schedule EPO 1B
List of Patient Co-Payments

* See Special Provisions on Last Page

Proc Code	Procedure Code Definition	Patient Co-Pay
D5520	Replace missing or broken teeth-complete denture (each tooth)	$34.00
D5610	Repair resin denture base	$36.00
D5620	Repair cast framework	$47.00
D5630	Repair or replace broken clasp	$48.00
D5640	Replace broken teeth-per tooth	$33.00
D5650	Add tooth to existing partial denture	$39.00
D5660	Add clasp to existing partial denture	$49.00
D5710	Rebase complete maxillary denture	$141.00
D5711	Rebase complete mandibular denture	$141.00
D5720	Rebase maxillary partial denture	$108.00
D5721	Rebase mandibular partial denture	$108.00
D5730	Reline complete maxillary denture (chairside)	$56.00
D5731	Reline complete mandibular denture (chairside)	$56.00
D5740	Reline maxillary partial denture (chairside)	$51.00
D5741	Reline mandibular partial denture (chairside)	$51.00
D5750	Reline complete maxillary denture (laboratory)	$100.00
D5751	Reline complete mandibular denture (laboratory)	$100.00
D5760	Reline maxillary partial denture (laboratory)	$93.00
D5761	Reline mandibular partial denture (laboratory)	$93.00
D5850	Tissue conditioning, maxillary	$26.00
D5851	Tissue conditioning, mandibular	$26.00
MAJOR SERVICES (Prosthodontic Codes - Fixed)		
D6210	Pontic-cast high noble metal	$274.00
D6211	Pontic-cast predominantly base metal	$250.00
D6212	Pontic-cast noble metal	$255.00
D6240	Pontic-porcelain fused to high noble metal	$276.00
D6241	Pontic-porcelain fused to predominantly base metal	$241.00
D6242	Pontic-porcelain fused to noble metal	$268.00
D6545	Retainer-cast metal for resin bonded fixed prosthesis	$100.00
D6750	Crown-porcelain fused to high noble metal	$280.00
D6751	Crown-porcelain fused to predominantly base metal	$251.00
D6752	Crown-porcelain fused to noble metal	$268.00
D6780	Crown-3/4 cast high noble metal	$272.00
D6790	Crown-full cast high noble metal	$283.00
D6791	Crown-full cast predominantly base metal	$256.00
D6792	Crown-full cast noble metal	$266.00
D6930	Recement fixed partial denture	$33.00
D6940	Stress breaker	$74.00
D6970	Cast post and core in addition to fixed partial denture retainer	$89.00

Delta Dental of Colorado
EXCLUSIVE PANEL OPTION (EPO)
Schedule EPO 1B
List of Patient Co-Payments

* See Special Provisions on Last Page

Proc Code	Procedure Code Definition	Patient Co-Pay
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$75.00
D6973	Core build up for retainer, including any pins	$64.00
D6976	Each additional cast post-same tooth	$0.00
D6977	Each additional prefabricated post-same tooth	$0.00
BASIC SURGERY (Oral Surgery Codes)		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$22.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$43.00
D7220	Removal of impacted tooth-soft tissue	$48.00
D7230	Removal of impacted tooth-partially bony	$60.00
D7240	Removal of impacted tooth-completely bony	$70.00
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications	$100.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$42.00
D7285	Biopsy of oral tissue-hard (bone, tooth)	$58.00
D7286	Biopsy of oral tissue-soft (all others)	$36.00
D7310	Alveoloplasty in conjunction with extractions-per quadrant	$34.00
D7320	Alveoloplasty not in conjunction with extractions-per quadrant	$49.00
D7471	Removal of lateral exostosis (maxilla or mandible)	$68.00
D7472	Removal of torus palatinus	$68.00
D7473	Removal of torus mandibularis	$68.00
D7510	Incision and drainage of abscess-intraoral soft tissue	$25.00
D7960	Frenulectomy (frenectomy or frenotomy)-separate procedure	$51.00
ORTHODONTIC CODES		
D8010	Limited orthodontic treatment of the primary dentition	$600.00
D8020	Limited orthodontic treatment of the transitional dentition	$750.00
D8030	Limited orthodontic treatment of the adolescent dentition	$840.00
D8040	Limited orthodontic treatment of the adult dentition	$935.00
D8050	Interceptive orthodontic treatment of the primary dentition	$730.00
D8060	Interceptive orthodontic treatment of the transitional dentition	$825.00
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,685.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,780.00
D8090	Comprehensive orthodontic treatment of the adult dentition	$1,980.00
D8210	Removable appliance therapy	$180.00
D8220	Fixed appliance therapy	$238.00
D8660	Pre-orthodontic treatment visit	$35.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$213.00

Delta Dental of Colorado
EXCLUSIVE PANEL OPTION (EPO)
Schedule EPO 1B
List of Patient Co-Payments

* See Special Provisions on Last Page

Proc Code	Procedure Code Definition	Patient Co-Pay
MISCELLANEOUS CODES		
D9110	Palliative (emergency) treatment of dental pain-minor procedures	$18.00
D9120	Fixed partial denture sectioning	$9.00
D9220	Deep sedation/general anesthesia-first 30 minutes	$56.00
D9221	Deep sedation/general anesthesia-each additional 15 minutes	$16.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$8.00
D9241	Intravenous conscious sedation/analgesia-first 30 minutes	$46.00
D9242	Intravenous conscious sedation/analgesia-each additional 15 minutes	$11.00
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$14.00

* **SPECIAL PROVISIONS:**

Services MUST be performed by a Delta Dental PPO dentist in order to be payable under this program.

Services are subject to the limitations, exclusions and governing policies of the program.

The submitted fee for any procedure NOT LISTED is the responsibility of the patient, up to the approved PPO fee.

DELTA DENTAL

Exclusive Panel Option (EPO) a feature of Delta Dental PPO

City and County of Denver #6791 Option I

MAXIMUM BENEFIT Calendar Year Orthodontic Lifetime	Unlimited. Available to Employee, Spouse and Dependent Children. See co-payment sch for additional details.
CALENDAR YEAR DEDUCTIBLE	No Deductible
WHO CAN BE COVERED	Dependents to age 26. Orthodontics for Employee, Spouse and dependent Children.

PPO*		COVERED SERVICES	BENEFIT INFORMATION (subject to Delta Dental gui
PREVENTIVE AND DIAGNOSTIC SERVICES			
Co-payment (see attached schedule of Co-payment listing)		Oral Evaluation	Limited to 2 evaluations in a 12 month period
		Bitewing X-rays	Limited to 1 set in a 12 month period
		Full Mouth X-rays or Panoramic	Limited to 1 in a 60 month period
		Routine Cleaning	Limited to 2 cleanings in a 12 month period
		Fluoride Treatments	Limited to 1 treatment in a 12-month period. To age 16
		Space Maintainers	For posterior primary teeth. To age 14
		Sealants	1 per tooth in 36 months. To age 15 on unrestored molars
BASIC SERVICES: Fillings, Endodontics (Root Canal), Periodontics (Gum Disease) and Oral Su (extractions)			
Co-payment (see attached schedule of Co-payment listing)		Amalgam Fillings	Benefits on the same surface limited to 1 in 12 months
		Resin, Composite	Benefits on the same surface limited to 1 in 12 months
		Oral Surgery (Extractions)	
		General Anesthesia	Benefit with covered Oral Surgery only
		Surgical Periodontal (gums)	Benefit once every 36 months
		Root Canal Therapy	
MAJOR SERVICES Crowns, Bridges, Partials, Dentures			
Co-payment (see attached schedule of Co-payment listing)		Crowns	Benefit 1 in 60 months on same tooth. Not a benefit under 12
		Dentures, Partials, Bridges	Benefit 1 in 60 months. Not a benefit under age 16
		Bridge/Denture Repair	
		Denture Rebase/Reline	Benefit 6 months after initial insertion. Then benefit 1 in 36
ORTHODONTICS (Braces)			
Co-payment (see attached schedule of Co-payment listing)		Complete Orthodontic Evaluation	
		Active Orthodontic Treatment. Orthodontics for Employee, Spouse and dependent Childre	

*The PPO percentage of benefits is based on the PPO Schedule of Allowance. There is no benefit outside of the PPO network

Important Note This form provides only a brief description of services covered under your contract and does not list thos services which are limited or excluded from coverage. Your Employee Benefit Booklet

DELTA DENTAL

Delta Dental PPO[SM] plus Premier Plan
City and County of Denver Group #6026 Option 2

MAXIMUM BENEFIT Calendar Year Calendar Year for Implants Orthodontic Lifetime	 $1,250 per person for PPO, Premier or Out of Network $1,000 per person for PPO, Premier or Out of Network $1,000 per person for PPO, Premier or Out of Network
CALENDAR YEAR DEDUCTIBLE Applies to Basic and Major if a PPO dentist is used. Applies to all Services if a Non-PPO dentist is used.	Individual Deductible- $ 25.00 Combination of in and out-of-network Family Deductible - $ 75.00 Combination of in and out-of-network
WHO CAN BE COVERED	Employee, Spouse and Dependent Children to age 26.

PPO Dentist	PREMIER Dentist	NON-PAR Dentist	COVERED SERVICES	BENEFIT INFORMATION (subject to Delta Dental guidelines)
PREVENTIVE AND DIAGNOSTIC SERVICES				
100%	80%	80%	Oral Evaluation	Limited to 2 evaluations in a 12 month period
			Bitewing X-rays	Limited to 1 set in a 12 month period
			Full Mouth X-rays or Panoramic	Limited to 1 in a 60 month period
			Routine Cleaning	Limited to 2 cleanings in a 12 month period
			Fluoride Treatments	Limited to 1 treatment in a 12 month period- to age 16
			Space Maintainers	For posterior primary teeth- to age 14
			Sealants	1 per tooth in 36 months- to age 15 on unrestored molars
BASIC SERVICES (Fillings, Endodontics (Root Canal), Periodontics (Gum Disease) and Oral Surgery (extractions)				
80%	50%	50%	Amalgam Fillings	Benefits on the same surface limited to 1 in 12 months
			Resin, Composite	Benefit for anterior and posterior teeth
			Oral Surgery (Extractions)	
			General Anesthesia	Benefit with covered Oral Surgery only
			Surgical Periodontal (gums)	Benefit once every 36 months
			Root Canal Therapy	
MAJOR SERVICES (Crowns, Bridges, Partials, Dentures)				
50%	50%	50%	Crowns	Benefit 1 in 60 months on same tooth- not a benefit under age 12
			Dentures, Partials, Bridges	Benefit 1 in 60 months- not a benefit under age 16
			Implants	
			Night Guards	
ORTHODONTICS (Braces)				
50%	50%	50%	Complete Orthodontic Evaluation	
			Active Orthodontic Treatment	

PPO Dentist- The PPO percentage of benefits is based on the PPO Schedule of Allowance.
Premier Dentist- The Premier percentage of benefits is limited to the Maximum Plan Allowance.
Non-participating Dentist- The non-participating percentage of benefits is limited to the out of network maximum. **You may have additional out-of-pocket costs by using a non-participating dentist.**

To find a dentist, visit our website at www.deltadentalco.com, or call Customer Relations at (800) 610-0201.

Important Note: This form provides only a brief description of services covered under your contract and does not list those services which are limited or excluded from coverage. Your Employee Benefit Booklet provides a more complete explanation of your coverage, including limitations and exclusions. If differences exist between this Summary of Benefits and your Employee Benefit Booklet, the Benefit Booklet will govern.

DELTA DENTAL

Delta Dental PPO[SM] plus Premier Plan
City and County of Denver Group #6793 Option 3

MAXIMUM BENEFIT Calendar Year Calendar Year for Implants Orthodontic Lifetime	 $2,000 per person for PPO, Premier or Out of Network $1,000 per person for PPO, Premier or Out of Network $1,000 per person for PPO, Premier or Out of Network
CALENDAR YEAR DEDUCTIBLE Applies to Basic and Major if a PPO dentist is used. Applies to all Services if a Non-PPO dentist is used.	Individual Deductible- $ 25.00 Combination of in and out-of-network Family Deductible - $ 75.00 Combination of in and out-of-network
WHO CAN BE COVERED	Employee, Spouse and Dependent Children to age 26.

PPO Dentist	PREMIER Dentist	NON-PAR Dentist	COVERED SERVICES	BENEFIT INFORMATION (subject to Delta Dental guidelines)
PREVENTIVE AND DIAGNOSTIC SERVICES				
100%	100%	100%	Oral Evaluation	Limited to 2 evaluations in a 12 month period
			Bitewing X-rays	Limited to 1 set in a 12 month period
			Full Mouth X-rays or Panoramic	Limited to 1 in a 60 month period
			Routine Cleaning	Limited to 2 cleanings in a 12 month period
			Fluoride Treatments	Limited to 1 treatment in a 12 month period- to age 16
			Space Maintainers	For posterior primary teeth- to age 14
			Sealants	1 per tooth in 36 months- to age 15 on unrestored molars
BASIC SERVICES Fillings, Endodontics (Root Canal), Periodontics (Gum Disease) and Oral Surgery (extractions)				
90%	80%	80%	Amalgam Fillings	Benefits on the same surface limited to 1 in 12 months
			Resin, Composite	Benefit for anterior and posterior teeth
			Oral Surgery (Extractions)	
			General Anesthesia	Benefit with covered Oral Surgery only
			Surgical Periodontal (gums)	Benefit once every 36 months
			Root Canal Therapy	
MAJOR SERVICES Crowns, Bridges, Partials, Dentures				
60%	50%	50%	Crowns	Benefit 1 in 60 months on same tooth- not a benefit under age 12
			Dentures, Partials, Bridges	Benefit 1 in 60 months- not a benefit under age 16
			Implants	
			Night Guards	
ORTHODONTICS Braces				
50%	50%	50%	Complete Orthodontic Evaluation	
			Active Orthodontic Treatment	

PPO Dentist- The PPO percentage of benefits is based on the PPO Schedule of Allowance.
Premier Dentist- The Premier percentage of benefits is limited to the Maximum Plan Allowance.
Non-participating Dentist- The non-participating percentage of benefits is limited to the out of network maximum. **You may have additional out-of-pocket costs by using a non-participating dentist.**

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