Basic Plus Plan
Summary Plan Description

for

STATE OF COLORADO
Employee Group Dental Plan

Delta Dental PPO Dental Plan

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MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, You have the right to:

- Receive information regarding terms and conditions of Your health care benefits;
- Be treated respectfully and with consideration;
- Receive all the Benefits to which You are entitled under Your booklet;
- Obtain complete information from a Provider regarding Your diagnosis, treatment, and prognosis, in terms You can reasonably understand;
- Receive quality health care through Providers in a timely manner and in an appropriate setting;
- Have a candid discussion, with Providers, of appropriate treatment options for Your condition, regardless of cost or benefit coverage;
- Participate with Your Provider(s) in decision-making about Your health care treatment;
- Refuse treatment and be informed by Your Provider(s) of the dental consequences;
- Receive wellness information to help You maintain a healthy lifestyle;
- Express concerns and complaints to the Plan Administrator about the care and services provided by Providers, and to have the Plan Administrator investigate and take appropriate action.
- File a complaint or appeal a decision with the Plan Administrator as outlined in the **Appeals** section and contact the Division of Insurance about a concern without fear of reprisal;
- Expect that Your personal health information will be maintained in a confidential manner;
- Make recommendations regarding Member rights and responsibilities policies.

As a Member, You have the responsibility to:

- Use Providers who will provide or coordinate Your total dental care needs, and to maintain an ongoing patient-Provider relationship;
- Provide complete and honest information about Your health care status and history;
- Follow the treatment plan recommended by Your Providers;
- Understand how to access care in non-emergency and emergency situations, and know Your health care Benefits as they relate to Out-of-Network coverage, Coinsurance and Copayments.
- Notify the Provider or the Plan Administrator about concerns You have regarding the services or dental care You receive;
- Be considerate of the rights of other Members, Providers and Plan Administration staff;
- Read and understand Your booklet and Covered Dental Services;
- Pay all Member payment requirements in a timely manner;
- Provide the Plan Claims Administrator with complete and accurate information about other dental care coverage and/or benefits You may carry;
- Participate in understanding Your dental problems and developing mutually agreed upon treatment goals with Your Provider.

INTRODUCTION

Your Dental Plan

We are pleased to introduce You to Your new dental plan. This Dental Plan, if used properly, will provide You one of the finest dental plans available anywhere. It is very important that You read this entire booklet to fully understand Your benefits.

DEFINITIONS SECTION

This section defines certain words as they are used by the companies that administer Your benefits. Reading this section will help You understand Your benefits as defined within the Summary Plan Description (SPD).

Benefit Year - Each Covered Person's **first** Benefit Year starts on the person's effective date and ends on the following June 30. After the Covered Person's first Benefit Year, all following Benefit Years start July 1 and end on the following June 30, or the last day of the month in which coverage ends, if earlier.

Class I Services - Diagnostic, Preventive and Adjunctive dentistry.

Class II Services - Basic dentistry.

Class III Services - Major dentistry.

Class IV Services - Orthodontic dentistry.

COBRA - Consolidated Omnibus Budget Reconciliation Act.

Coinsurance - A percentage that a Covered Person pays for Covered Services after his or her Deductible is met.

Completed – Covered Services are deemed to be Completed as follows:

- 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.

Covered Person - The Employee and any of the Employee's Eligible Dependents who are enrolled under the Plan. "You" and "Your" refer to the Covered Person.

Covered Services - The services that have been determined to be benefits under the terms and conditions of the Plan.

Deductible - The amount a Covered Person must pay each Benefit Year before a Plan pays for Covered Services.

Delta Dental Premier Participating Dentist - A Delta Dental Premier Participating Dentist means a Dentist who is licensed to practice and has executed an agreement with Delta Dental to become a participating Dentist. The Premier Dentist agrees not to charge You over and above the Maximum Plan Allowance for Premier Dentists.

Delta Dental PPO Dentist - means a Dentist licensed to practice who has executed a PPO Dentist Agreement with Delta Dental of Colorado to participate in that program.

Dentist - A person duly licensed to practice dentistry by the government authority having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered as a Doctor of Medical Dentistry (DMD) or a Doctor of Dental Surgery (DDS). A Dentist is a person recognized by the Plan to provide dental care for Covered Persons. Dentists may have agreements with Delta Dental. The agreement a Dentist has with Delta Dental affects the level of benefits You receive. Your Coinsurance and Deductible amounts depend on whether the Dentist You choose is In-Network or Out-of-Network.

Effective Date - The date the Employee or an Eligible Dependent is enrolled on the Plan's membership records for this coverage. This date is designated and provided to the Administering Company by Your Employer.

Eligible Dependent – Dependent is defined by the Colorado Revised Statutes (CRS), section 24-50-603 as an Eligible Employee's legal spouse; each unmarried child, including adopted children, stepchildren and foster children through the end of the month in which the child turns 25 years of age and for whom the Eligible Employee is the major source of financial support or has the same legal residence, or for whom the Eligible Employee is directed by court order to provide coverage under the Plan; or an unmarried child of any age who has either a physical or mental disability, as defined by the Plan, not covered under other government programs and for whom the Eligible Employee is the major source of financial support or for whom the Eligible Employee is directed by court order to provide coverage under the Plan.

Emergency Services - Dental services which are required for alleviation of severe pain or for immediate diagnosis and treatment of unforeseen conditions which, if not immediately diagnosed and treated, would lead to serious impairment of the patient's health.

Employee - "Employee" is defined by the Colorado Revised Statutes (CRS), section 24-50-603 as any officer or employee under the state personnel system of the state of Colorado whose salary is paid by state funds or any employee of the department of education, the Colorado commission on higher education, or the Colorado school for the deaf and the blind whose salary is paid by state funds. An "Employee" includes any officer or employee of the legislative or judicial branch, any elected or appointed state official or employee who receives compensation other than expense reimbursement from state funds, and includes any member of the board of assessment appeals. An "Employee" does not include persons employed on a temporary basis, nor any state employee that is not covered under the state classified personnel system.

Employer - The State of Colorado, acting through the Department of Personnel, or its designee.

Extended Coverage (Extension of Benefits) - Upon termination of coverage under the Plan, specific dental services may be considered for continued benefits as described under the General Section.

Group - The State of Colorado.

In-Network Coverage - The level of coverage that gives You the highest benefit level at the lowest out-of-pocket expense to You. To receive In-Network Coverage You must receive services from a PPO Dentist.

Master Contract - The contract between the State of Colorado and the Administering Company. This contract contains the procedures for administering the Plan and detailed criteria for eligibility of benefits The Master Contract will prevail in the event of a conflict with the rules promulgated pursuant to Colorado Revised Statutes (CRS) 24-50-601 through 617.

Maximum Plan Allowance (MPA) – The maximum allowable amount as determined by Delta Dental for a procedure. Benefits are calculated on the lesser of the submitted charge or the maximum plan allowance.

Member – The enrolled Eligible Employee and Your enrolled Eligible Dependents, including any Employee or Dependent who elects to continue coverage under COBRA.

Non-Participating Dentist - A Dentist who has not made any agreements with Delta Dental to limit charges for Covered Services or to bill Delta Dental directly. If You use a Non-Participating Dentist, **You pay** the Dentist's full-billed charges and Delta Dental will reimburse **You** according to the PPO Discounted Fee Schedule. Any difference in costs between the Dentist's full-billed charges and the amount paid to You by Delta Dental is **Your** responsibility.

Open Enrollment - A period of time provided once each year when Employees and Eligible Dependents may enroll in the State of Colorado's Dental Plan. Coverage will be effective the next July 1, the first day of the following Benefit Year.

Out-of-Network Coverage - Out-of-Network Coverage is the level of benefit You receive when You receive services from a Non-Participating Dentist. Out-of-pocket expenses are generally higher for Out-of-Network Coverage.

Plan - The State of Colorado Dental Plan that determines the benefits, limitations, exclusions and payments for the Plan.

Plan Year - A period of twelve (12) consecutive months, beginning July 1, during which the terms of the Group Policy are in force.

Plan Administrator - Colorado Dental Service Inc., d.b.a. Delta Dental of Colorado, herein called "Delta Dental" is a nonprofit health care service corporation licensed in the state of Colorado. Delta Dental is currently the Plan Administrator for the Plan.

PPO Dentist's Allowable Fee means the fee from the PPO Discounted Fee Schedule that the PPO Dentist has contractually agreed with Delta Dental to accept for treating Eligible Persons under this plan, or the fee actually charged, whichever is less, for a single procedure

Pre-treatment Estimate - Advance written estimate of the Benefits payable for the planned course of treatment.

Qualifying Event – An event such as birth, adoption, marriage, loss of other coverage, etc., that allows an Employee to enroll, modify or terminate coverage.

Started – Covered Services are deemed to have Started as follows:

- 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.

Summary Plan Description (SPD) - This document for the Plan that explains the benefits, limitations, exclusions, terms and conditions of Your coverage.

You and Your – mean an employee covered under the Plan.

MEMBERSHIP

Eligible Employees

You are in an Eligible Class for coverage under the Plan if You are a person employed by the State of Colorado, who meets the definition of Employee as defined in Colorado Revised Statues (CRS) 24-50-603(7) and You are employed on a Full-Time or Part-Time Basis, working Your normal hours as set by Your Employer (not temporary work) for Your Employer. Under C.R.S. 24-50-603(7), an "Employee" means any officer or employee under the state personnel system of the State of Colorado whose salary is paid by state funds or any employee of the department of education, the Colorado commission on higher education, or the Colorado school for the deaf and the blind whose salary is paid by state funds. "Employee" includes any officer or employee of the legislative or judicial branch, any elected or appointed state official or employee who receives compensation other than expense reimbursement from state funds, any elected state official who does not receive compensation other than expense reimbursement from state funds, and includes any member of the board of assessment appeals. "Employee" does not include persons employed on a temporary basis, leased employees or independent contractors.

Eligible Employees may apply for coverage for themselves and their eligible dependents by completing appropriate state forms, which may be electronic. Such forms, must be submitted (electronic submission may be required) within 31 days of date of hire, during the annual Open Enrollment period, and certain special enrollment events. The Effective Date will be (1) the next first of the month following the Employee's date of hire, or (2) if enrolling during the annual Open Enrollment period, the next first of the Plan Year, or (3) if enrolling within 31 days of a special enrollment event, the next first of the month following submission of the appropriate forms and documentation.

Employee Responsibilities

Initial enrollments, changes to enrollment and terminations of enrollment require that You complete, sign and date the appropriate state forms, which may be electronic, in accordance with criteria as defined in law and regulations, procedure and written directives. You also must provide supporting documentation, if requested. Your signature on the enrollment form, which may be electronic, attests that the information provided is true and complete, authorizes the appropriate payroll deduction or authorizes the Employer to stop Your contributions.

It is unlawful for You or Your Dependent to provide false, incomplete or misleading facts or information on any State enrollment form, affidavit, claim or other document for the purpose of defrauding or attempting to defraud the State of

Colorado. Such actions may result in coverage being terminated or denied. The State reserves the right to request documentation to establish the eligibility of an Employee or Dependent.

Once enrolled in the Plan, You must verify the accuracy of Your enrollment elections and payroll deductions. Should You find an administrative error, You must notify Your department's HR or benefits administrator within 10 days of the first payroll deduction. Failure to notify Your department's HR or benefits administrator within the specified time period will result in having to maintain enrollment in the incorrect option until the next annual Open Enrollment period or Special Enrollment Event.

Any Special Enrollment Event that permits enrollment or modification of enrollment must be reported by completing the appropriate state forms, which may be electronic, and providing supporting documentation within 31 days of the Special Enrollment Event. If the appropriate enrollment forms are not completed and filed with the Employer on or before the 31st day of the Special Enrollment Event, Your enrollment or modification will only be permitted during the next annual Open Enrollment period.

To enroll in the Plan, You must elect to have contributions deducted on a pre-tax or after-tax basis, as defined by the State of Colorado Salary Reduction Plan, law and regulations, rules and written directives. Your contribution is deducted from Your paycheck or, under certain circumstances, is made by personal payment for the selected Plan. The State contribution is added to Your contribution to complete the total contribution for the selected Plan. If You are enrolled and work or are on paid leave, approved Family Medical Leave or disability leave one or more regularly scheduled workdays in a month, You are eligible for the full State benefit contribution. When there is a difference in Your contribution compared to the actual contribution due, You must pay the difference. Members who do not receive compensation from the Employer due to leave of absence, termination of employment or any other reason are responsible for remitting payment of the contribution. Contributions are due on the first calendar day of the month of coverage and are considered timely paid if received by the Plan Administrator by the last calendar day of the month.

Leaves of Absence

While on an Approved Unpaid Leave of Absence, voluntary furlough, family/medical leave or short-term disability leave, You may continue coverage under the Plan for a period of up to six months. If You fail to pay Your contribution by the due date while on unpaid leave, Your coverage in the Plan will be terminated. Re-enrollment is subject to conditions of the annual Open Enrollment and applicable law, procedure and written directives.

If You stop Active Work to take a qualified military leave of absence under the Uniformed Services Employment and Reemployment Rights Act (USERRA), You can elect to continue coverage for Yourself and Your Dependents for a period of 24 months. Continuation of coverage under COBRA and USERRA run concurrently.

Reinstatement

An Employee who re-enters an Eligible Class within 30 days after the date his or her coverage ends because he or she no longer performs Active Work on a Full-Time Basis in an eligible class shall be reinstated with no break in coverage.

Eligible Dependents

To be eligible for Dependent Coverage under the Plan, Your Dependent(s) must be eligible as defined in Colorado Revised Statues (CRS) under C.R.S. 24-50-603(5). If Your dependents cease to meet the eligibility requirements, coverage may be continued as later described in the Continuation Coverage (COBRA) section.

Dependent Definition

Dependent is defined by the Colorado Revised Statutes (CRS), section 24-50-603 as an Eligible Employee's legal spouse; each unmarried child, including adopted children, stepchildren and foster children through the end of the month in which the child turns 25 years of age and for whom the Eligible Employee is the major source of financial support or has the same legal residence, or for whom the Eligible Employee is directed by court order to provide coverage under the Plan; or an unmarried child of any age who has either a physical or mental disability, as defined by the Plan, not covered under other government programs and for whom the Eligible Employee is the major source of financial support or for whom the Eligible Employee is directed by court order to provide coverage under the Plan.

Your eligible Dependents include:

1. Your legal spouse. If the spouse is common-law, a signed common-law affidavit and supporting documentation is required as proof.
2. Your dependent child. An unmarried child (including an adopted child, stepchild, Foster Child, or court-ordered) under 19 years of age can be covered under the terms of the Plan. For a child who is over the age of 19 and under age 25, to be considered eligible the child must either have the same legal residence as the parent, or be financially dependent upon the parent. The child is automatically removed from coverage as a Dependent at the end of the month in which they turn age 25 unless they qualify as an over-age Dependent child.
3. Your adopted child. Your adopted child is an eligible Dependent upon Placement For Adoption, the circumstances under which an Employee assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement terminates when the legal obligation for support terminates.
4. An unmarried child who is required to be covered by You or Your spouse pursuant to Qualified Medical Child Support Order, as defined by (CRS)24-50-603, whether or not the Child lives with You or whether You are the child's major source of financial support.
5. Your Disabled Dependent Child. An unmarried child who is 25 years of age or older, medically certified as Disabled, and financially dependent on the parent, can be covered under the terms of this Plan. A completed Mentally or Physically Disabled Dependent Form must be submitted for the Disabled Dependent to be eligible for or to continue coverage. First proof of incapacity must be given to the Plan (at Your expense) within 31 days of the Child's 25th birthday. Completion of the Mentally or Physically Disabled Dependent Form does not guarantee continued coverage unless such request is approved by the Plan. The Employee and the Disabled Dependent's Physician must complete this form and submit it to the payroll/personnel administrator. You may obtain a Mentally or Physically Disabled Dependent Form from Your payroll/personnel administrator.
6. A grandchild. A child born to Your covered minor Dependent child may be covered as a Dependent under this Plan providing You submit the appropriate change form and documentation within 31 days of the grandchild's birth. The grandchild is covered only as long as the child/parent is covered under the Plan. A grandchild of an Employee or an Employee's spouse, other than a Child born to a minor Dependent Child, is not eligible for coverage unless the Plan receives and approves proof of legal custody. The Employee must be the grandchild's major source of financial support.

Coverage For Dependents Under Age 5

Dependents under age five (5) are covered at no premium cost to You, however, your dependent under age 5 must be enrolled in the plan to be covered. If You are enrolled during the month dependent(s) reach the age of five (5), You must complete the appropriate online enrollment form to add Your dependent(s) and authorize Your agency payroll/personnel administrator to change Your payroll deduction (if applicable).

When Both Parents Are Eligible Employees

No person may be covered as a Dependent of more than one Employee. With respect to a husband and wife, who are Eligible Employees, no one may be covered as a Dependent and also as an Employee, and if both parents are covered as Employees, children may be covered as dependents of one Employee only. Dependents in active military service are not covered under the Plan. A Member can only be covered under one health plan option sponsored by the Employer. Dependents must be covered under the same health plan option as the Employee.

NOTE: If You elect Dependent Coverage and wish to enroll Your Dependent Child or Children, You must provide the requested information (e.g., name, birth date, gender and Social Security Number). Dependents are not covered automatically by electing Dependent Coverage.

When Coverage Begins For Eligible Employees and Eligible Dependents

Coverage in the Plan is effective for You and Your eligible dependents on the first day of the month following Your date of hire, provided the appropriate State forms, which may be electronic, are completed and submitted within 31 days of the date of hire. You and Your dependents may also become eligible for coverage due to a Special Enrollment Event. The Effective Date of coverage for Special Enrollment Events is the first of the month following the date the appropriate enrollment forms and provision of supporting documentation are completed and submitted, provided the enrollment is completed within 31 days of the Special Enrollment Event. If the appropriate enrollment forms are not submitted on or before the 31st day, You and Your dependents will be considered Late Enrollees and Your enrollment or modification will only be permitted during the next annual Open Enrollment period.

Late Enrollees

If You do not Enroll within 31 days after You are eligible for coverage, You will be a Late Enrollee. If You do not enroll Your dependents within 31 days after You are eligible for coverage or Your dependents are not enrolled within 31 days after they become eligible, or You wish to restore Dependent coverage, which ended because You did not make required Contributions, Your dependents will be considered Late Enrollees.

A Late Enrollee may enroll only during the next annual Open Enrollment period, as determined by the Plan. Until You are properly enrolled in the Plan, You are not eligible for benefits.

What Is Open Enrollment?

Open Enrollment is the period of time held each year when Eligible Employees can enroll, modify or terminate enrollment in the Plan. You must make a positive election to enroll in the Plan each Plan Year during the Open Enrollment period. You and Your eligible dependents who are not enrolled in the Plan may complete the appropriate state forms, which may be electronic, to enroll during Open Enrollment. Your department's HR or benefits administrator will notify You of Open Enrollment. You may also contact Your department's HR or benefits administrator at any time for Open Enrollment information. Anyone who enrolls during Open Enrollment and has the applicable payroll deduction will have an Effective Date of July 1.

Special Enrollment Events

You or an Eligible Dependent may enroll for coverage during a special enrollment period for a Special Enrollment Event under the following circumstances:

1. Loss of Other Coverage. If You or an Eligible Dependent
   a. were covered under another group health plan (including COBRA continuation) or had other dental insurance coverage at the time enrollment in the Plan was declined; and
   b. have lost or will lose coverage under the other plan as a result of loss of eligibility (due to such reasons as termination of employment, change of employment status, death of a spouse, divorce, legal separation or cessation of the Employer's contributions to such coverage) or have exhausted COBRA continuation coverage,

   You or an Eligible Dependent may enroll in the Plan within 31 days after loss of that coverage. Coverage in the Plan will be effective on the first of the month following completion and submission of the appropriate state forms, which may be electronic, and provision of supporting documentation, if required, provided the enrollment is completed within 31 days of the Special Enrollment Event.

2. Acquisition of Dependents. If You did not enroll in the Plan when first eligible and acquire a Dependent through marriage, birth, adoption or Placement For Adoption, You and the newly acquired Dependent(s) may enroll within 31 days of the date of marriage, birth, adoption or Placement For Adoption, as a Special Enrollment Event. In the case of the birth, adoption or placement of a Child, Your spouse and any other Dependent children may also enroll as Your Dependent(s), if otherwise eligible for coverage. Coverage will be effective on the date of birth, adoption or Placement For Adoption. In the case of marriage, coverage will be made effective on the first day of the month following enrollment. If the acquisition of dependents necessitates a change of contribution tier, the change will be effective the first of the month following the date of birth, adoption or Placement for Adoption; or in the case of marriage, the first of the month following completion of the appropriate state forms, which may be electronic, and provision of supporting documentation, provided the enrollment is completed within 31 days of the Special Enrollment Event.

If You or an Eligible Dependent do not enroll for coverage when You are hired, or during an Open Enrollment period or during a Special Enrollment period for a Special Enrollment Event, You or Your Dependent will be considered a Late Enrollee. Late Enrollees, Employees and dependents who do not properly enroll in coverage under the Plan are not covered and are not eligible to receive any benefits under the Plan.

When Coverage Can Be Changed

After the Open Enrollment period is closed, You may change Your benefits election during the Plan Year only after a qualifying status change. Within 31 days of a qualifying status change, You must submit a written request to Your department's HR or benefits administrator on the appropriate state forms, which may be electronic, specifying the change You are seeking. Upon approval of the change by Your Human Resources/ Benefits Office, the election change is then completed by You on the appropriate state forms, which may be electronic,. This approved election change will continue until another eligible event occurs or until You change Your election during the next annual Open Enrollment period.

Eligible Events That May Allow Election Changes

All changes requested after Open Enrollment must be approved by Your department's HR or benefits administrator. Requested changes must be *on account of and corresponding with* a qualifying status change that affects eligibility for coverage under the Plan. Election changes must be requested on the appropriate state forms, which may be electronic, within 31 days of the qualifying status change event. Changes allowed under federal regulations must fit within one of these categories: HIPAA, FMLA, COBRA or Qualifying Status Change (see the following definitions).

NOTE*:* See Your department's HR or benefits administrator to request a change during the Plan Year. Your department's HR or benefits administrator will help You determine if an election change is allowed based on Your individual situation.

When Coverage Ends

For Employees:
Your coverage will end on the date of the first of these events:

1. The last day of the month in which You terminate employment for any reason, including death and retirement, except that:
   a. if You stop Active Work due to an Approved Unpaid Leave of Absence, Your coverage will continue as long as You make payment of the required Contributions. Your coverage will continue up to six months for an Approved Unpaid Leave of Absence.
   b. if You stop Active Work to take a qualified military leave of absence pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), You may elect to continue coverage subject to payment of Contributions. See the section on continuation of coverage under USERRA later in this Section.
2. You stop paying required Contributions in a timely manner.
3. As to any one coverage or class, the date the Plan is amended or changed to exclude that coverage or class.
4. The date the Plan ends.
5. The date You or any of Your dependents commit fraud against the State or the Plan or makes an intentional misrepresentation of material fact.

For Dependents:
A Dependent's coverage will end on the earlier of:

1. the date Your coverage ends;
2. the end of the month in which the Dependent ceases to be eligible as defined by the Plan, such as:
   a. the end of the month in which a Dependent reaches age 25;
   b. the end of the month in which a Dependent is no longer financially dependent upon the Employee, or no longer resides at the same legal residence.
3. The end of the month in which the eligible Dependent child marries.
4. The date a Dependent enters the armed forces of any country on active full-time duty.
5. The end of the month in which a Dependent becomes an eligible Employee.
6. The end of the month of Your final divorce decree or legal separation from an eligible Employee.

Terminations of enrollment require that You complete, sign, date and submit the appropriate change forms, which may be electronic, in accordance with criteria as defined in law and regulations, procedure and written directives. You also must provide supporting documentation, if requested. The change form may be completed in

advance of the date that Your Dependent loses eligibility (e.g., prior to a Dependent's birthday or impending marriage), but the change form must be completed no later than 31 days following the date that Your Dependent loses eligibility. Your signature on the change form, which may be electronic, attests that the information provided is true and complete and authorizes the Employer to stop Your contributions, if applicable.

Continuation of Coverage under COBRA and USERRA

If Your coverage under the Plan terminates because of certain qualifying events, You can continue Your coverage for a limited period of time under COBRA. See the COBRA notice included in the Notice section at the back of this Summary for more information on continuing coverage under COBRA.

USERRA established requirements that Employers must meet for certain Employees who are involved in the Uniformed Services. In addition to the rights under COBRA continuation of coverage, You are entitled under USERRA to continue the coverage You had under the group health plan.

"Service in the Uniformed Services" means the performance of active duty in the Uniformed Services under competent authority, which includes training, full-time National Guard duty and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of the assigned duties.

When You take a leave for Service in the Uniformed Services, USERRA coverage for You and Your covered Dependents for whom coverage is elected begins the day after You and Your covered dependents lose coverage under the Plan and it continues for a maximum period of up to 24 months.

If You are entitled to COBRA continuation of coverage, then both COBRA and USERRA coverage are concurrent. This means both COBRA coverage and USERRA coverage will begin upon commencement of Your leave. The administrative policies and procedures described for COBRA continuation coverage will also apply to USERRA coverage. In some instances, COBRA coverage may continue longer. Additional information on COBRA continuation coverage is described in this booklet.

If coverage under USERRA is elected, You and Your Dependents will be required to pay up to 102% of the applicable group rate. However, if Your Uniformed Service leave of absence is less than 31 days, You are not required to pay more than the amount that You pay as an active Employee for that coverage. When You return to Active Work from a qualified military leave of absence, Your coverage will be reinstated as required by USERRA.

If You stop Active Work due to temporary layoff You are eligible to continuation of coverage under COBRA. If You return to active employment within 30 days, Your coverage will be reinstated with no break in coverage, subject to payment of Contributions.

NOTE: You and Your eligible Dependents may have the right to select COBRA continuation coverage following termination of coverage.

How to Use the Basic Plus Dental Plan

Delta Dental PPO is the name of the Preferred Provider Organization (PPO) network for the State of Colorado's Basic Plus Plan.
There are three choice levels of Dentists:

1. In-Network PPO Dentists;
2. Out-of-Network Premier Dentists; and
3. Out-of-Network Non-Participating Dentists.

You do not have to select a particular Dentist to receive dental benefits. Since there are no restrictions on which Dentist You may select, You have the freedom of choice. However, using the In-Network PPO provides for lesser "out-of-pocket" costs.

How the Discount Fee Schedule Works

All In- and Out-of-Network Dentists are paid according to the PPO Discounted Fee Schedule. This schedule determines the maximum amount of Delta Dental's reimbursements for Covered Services. Out-of-network Dentists generally charge more for a particular service. Therefore, You are responsible for the difference in the Coinsurance up to the Maximum Plan Allowance (MPA) for Premier Dentists, or the full-billed charges for non-participating Out-of-Network Dentists.

PPO Dentists (In-Network)

Delta Dental PPO Dentists have agreed to accept the PPO Discounted Fee Schedule. If You or Your Eligible Dependents live in an area where an In-Network PPO Dentist is not available, You must drive to an In-Network Dentist to receive this higher level of benefits.

- Dentist agrees to PPO Discounted Fee Schedule. You are responsible for Coinsurance and Deductibles.
- Dentist will submit claim to Delta Dental.
- Dentist will charge You ONLY the Coinsurance and Deductible on the day services are performed.

Premier Dentists (Out-of-Network)

Premier Dentists have signed contractual agreements with Delta Dental and have agreed to accept Delta Dental's portion of the payment that will be paid according to the Maximum Plan Allowance. After a PPO Discounted Fee payment is received by the Dentist from Delta Dental, the DeltaPremier Dentist agrees not to charge You over and above the Maximum Plan Allowance (MPA).

- Dentist payment is based on PPO Discounted Fee Schedule. Dentist can charge difference in PPO payment up to the MPA. Dentist is LIMITED to the MPA.
- Dentist will submit claim to Delta Dental. Delta Dental will pay the Dentist on behalf of the Plan and send You an Explanation of Benefits indicating the amount You are responsible for paying.

Dentist may charge Coinsurance and Deductible on the day services are performed.

Non-Participating Dentists (Out-of-Network)

Non-Participating Dentists **have no agreements** with Delta Dental. Therefore, if You choose a Non-Participating Dentist, You must pay the Dentist the full-billed charges and Delta Dental will reimburse **You** according to their PPO Discounted Fee Schedule. Any difference in costs between the Dentist's full-billed charges and the amount paid to You by Delta Dental is Your responsibility.

- Your Dentist may require You to pay the **total** charges on the day services are performed.
- You will need to submit a claim form to Delta Dental. Delta Dental will reimburse **You,** on behalf of the Plan, for the services, NOT the Dentist.
- Payment to **You** is based on the PPO Discounted Fee Schedule. The Dentist can charge ANY amount above the PPO Discounted Fee payment. You are responsible for any difference.

How To File A Claim

You do not have to fill out a claim form when using an In-Network PPO Dentist or a Premier Dentist. If You use a Non-Participating Dentist who chooses not to submit a claim to Delta Dental, You will have to file Your own claim. A claim form is included with Your enrollment materials. Send the claim to the address on the claim form. Additional claim forms may be obtained by visiting the Employee Benefits website at www.state.co.us/benefits and clicking on "dental," then select "claim form" at the bottom of the drop-down menu. You may also call Delta Dental's toll-free customer service number listed on the back page of this booklet.

Note: You are expected to file claims in a timely manner. The Plan will not be obligated to pay claims submitted more than twelve (12) months (365 calendar days) after the date the service was provided.

When You File A Claim (only required if You choose a Non-Participating Dentist)

- **You must** submit a separate claim form for each Dentist that provided Covered Services.
- **You must** also submit a separate claim form for each Covered Person when You are submitting charges for more than one covered family member.
- Make copies of the Dentist's bills for Your own records.
- Complete Your portion of the form and ask the Dentist to complete the remaining information. If the office will not complete the form, ask them to provide You with an original itemized bill that contains all the necessary information for processing Your claim. Balance due statements, cash register receipts and canceled checks are not acceptable.
- Make sure the information on the claim form and the statement is complete and readable, otherwise it might cause a delay in payment.

Pre-Treatment Estimate

A Pre-treatment Estimate is recommended when Your Dentist's suggested treatment plan exceeds $400.00. Your Dentist may submit the treatment plan to Delta Dental for review before any work is actually done. A Pre-treatment Estimate of benefits allows both You and Your Dentist to know exactly what is covered and what Your Plan will pay. There is no additional charge to have a Pre-treatment Estimate done. Under most circumstances, a Pre-treatment Estimate constitutes an estimate for payment when the exact services are provided within sixty (60) days of a signed Pre-Treatment Estimate date, subject to any prior payment or benefit maximum reached and provided the patient is eligible on the date of service.

A Pre-treatment Estimate is recommended for the following procedures:
- special restorations;
- removable prosthodontics;
- fixed prosthodontics;
- endodontics;
- oral surgery (except emergency procedures);
- periodontal treatment; and
- orthodontic treatment plans.

COVERED DENTAL SERVICES

Plan Year Benefit Maximum

Each eligible employee and each eligible dependent may receive up to $1,500.00 of covered dental benefits for Diagnostic, Preventive, Basic and Major Services each Plan Year.

Plan Year Deductible

Each eligible employee and each eligible dependent is responsible for the first $50.00, or a maximum of $150.00 per family, of covered dental services each Plan Year. Diagnostic and Preventive Services are not subject to the deductible.

Lifetime Orthodontic Benefit Maximum

Each eligible employee and each eligible dependent may receive up to $1,500 per lifetime for Orthodontic Services.

COINSURANCE PERCENTAGES

Covered Services	PPO Dentist In-Network	Participating Dentist Out-of-Network	Non-Participating Dentist Out-of-Network
*Class I: Preventive, Diagnostic and Adjunctive Services	100% of PPO Discounted Fee	100% of PPO Discounted Fee. You pay difference between Delta Dental's payment & dentist's MPA fee	100% of PPO Discounted Fee. You pay difference between Delta Dental's payment & dentist's full-billed charges.
*Class II: Basic Services	80% of PPO Discounted Fee	80% of PPO Discounted Fee. You pay difference between Delta Dental's payment & dentist's MPA fee	80% of PPO Discounted Fee. You pay difference between Delta Dental's payment & dentist's full-billed charges.
*Class III: Major Services	50% of PPO Discounted Fee	50% of PPO Discounted Fee. You pay difference between Delta Dental's payment & dentist's MPA fee	50% of PPO Discounted Fee. You pay difference between Delta Dental's payment & dentist's full-billed charges.
*Class IV: Orthodontic Services (for all eligible employees and dependents)	50% of PPO Discounted Fee	50% of PPO Discounted Fee. You pay difference between Delta Dental's payment & dentist's MPA fee	50% of PPO Discounted Fee. You pay difference between Delta Dental's payment & dentist's full-billed charges.

***Costs will vary depending upon which dental providers are utilized.**

BENEFITS

This Summary Plan Description (hereinafter referred as the "SPD") is part of the legal agreement between You (a Member) and the State of Colorado Dental Plan, (hereinafter referred as "the Plan"). As a Member, You are bound by all of the terms of this SPD. In exchange for Your contribution payment, the Plan agrees to pay for all or part of Covered Services as described in this SPD. Our provision of benefits to You is conditional on timely receipt of contributions.

The legal agreement between You and the Plan includes the following documents:

- This SPD and any revisions made to it.
- Your Enrollment/Change Form.
- The Master Contract.
- The Colorado Revised Statutes and rules promulgated thereunder governing the State of Colorado Employee Benefit Plans.

The above documents contain all the terms of the legal agreement between You and the Plan, and supersede all other statements and contracts, oral or in writing, with respect to the subject matter of this SPD. No change or modification or waiver of any of the provision of the Plan will be valid unless it is in writing, approved and signed by an authorized representative of the Plan.

I. DIAGNOSTIC, PREVENTIVE AND ADJUNCTIVE SERVICES

Diagnostic - Provides the necessary procedures to assist the dentist in evaluating the conditions existing and the dental care required. Covered Diagnostic Services include:
Oral Examination - to include initial, periodic or emergency
Dental X-Rays - to include complete (full mouth) series, single x-rays, or bitewings

Preventive - Provides the necessary procedures or techniques to prevent the occurrence of dental abnormalities or disease. Covered Preventive Services include:
Dental Cleaning - to include removal of all deposits and/or stains, and polishing as a single complete service

Adjunctive - Services including Emergency Services treatment performed as a temporary measure to relieve pain.

Limitations On Diagnostic, Preventive And Adjunctive Benefits

a) Cleanings (adult and child) and oral examinations are a benefit only twice in a Plan Year period, unless special need exists. For payment purposes, an adult cleaning is not a benefit for persons under age fourteen (14).
b) Topical fluoride application is a benefit only to children to age fifteen (15), and is a benefit only twice in a Plan Year period.
c) Complete mouth x-rays are a benefit only once in a thirty-six (36) month period, unless special need exists.
d) Bitewing x-rays are a benefit only twice in a Plan Year period and are not a benefit in addition to a complete series.
e) Benefit for examination will not be made when performed in conjunction with any covered Adjunctive Service.
f) Benefit for covered diagnostic services may be made toward the cost of special diagnostic services or techniques and the patient shall be responsible for the portion of the dentist's fee in excess of the Delta Dental allowance.
g) Space maintainer is a benefit only for premature loss of posterior deciduous (baby) teeth for children to age nineteen (19).
h) Sealant Benefits include the application of sealants only to permanent molar teeth with the occlusal surfaces intact, no caries (decay), and with no restorations.
i) Separate benefit shall not be made for any preparation or conditioning of the tooth or any other procedure associated with sealant application.
j) Sealant Benefits do not include any repair or replacement of a sealant on any tooth within thirty-six (36) months of its application. Such repair or replacement is considered included in the fee for the initial placement of the sealant.
k) Sealants are a benefit only for eligible dependent children to age fifteen (15).

II. BASIC SERVICES

Restorative - Provides the necessary procedures to restore the teeth other than special restorative. Covered Basic Restorative Services include Amalgam, Silicate and Resin Restorations.

Limitations On Basic Restorative Benefits

a) Benefits for the same covered basic restorative service shall not be provided more than once in any twelve (12) month period.
b) Allowance for amalgam on posterior (back) teeth or intraorally cured (placed and hardened completely in the mouth) resin or plastic restorations (fillings) on anterior (front) teeth may be made toward the cost of more expensive procedures or materials selected, and the patient shall be responsible for the portion of the dentist's fee in excess of the Delta Dental allowance.

Endodontics - Includes the necessary procedures for pulpal and root canal therapy.

Oral Surgery - Extractions, includes wisdom teeth and certain other surgical services including pre- and post-operative care and associated covered anesthesia.

Periodontics - Services for periodontal cleaning, surgical and non-surgical treatment of gums and bone supporting teeth.

Limitations On Endodontic And Periodontic Services

a) Covered surgical periodontic services are a benefit only once in a three (3) year period and covered adjunctive periodontic services are a benefit only once in a two (2) year period, unless evidence of special need is provided to the Plan.
b) Pulpotomy, Pulpectomy is a benefit only for deciduous (baby) teeth.

III. MAJOR SERVICES

Special Restorative - Crowns, jackets, cast, fused or other laboratory processed restorations, including gold restorations for teeth which cannot be restored with amalgam on posterior teeth or resin/plastic on anterior teeth.

Limitations On Special Restorative Benefits

a) If more than one restoration is used to restore a tooth, benefit will not exceed the covered amount for a single covered service.
b) Special restorative services are a benefit only once in a five (5) year period for procedures involving the same teeth.
c) Special restorative services are not a benefit for children under age twelve (12).

Prosthodontics and Prosthodontic Maintenance - Services for construction or repair of fixed bridges, removable partial and complete dentures to replace completely extracted or missing natural permanent teeth. Additional services for rebase or reline of dentures, recementation of crowns, inlays or onlays.

Limitations On Prosthodontic Benefits

a) Replacement of an existing prosthetic appliance is a benefit once in five (5) years and only if the appliance is unsatisfactory and cannot be made satisfactory.
b) A covered prosthodontic appliance is a benefit only after five (5) years has elapsed for any payment of covered special restorative benefit for the same tooth.
c) The Plan will pay the allowed percentage of the dentist's fee for a standard cast base metal and/or acrylic partial denture or a standard complete denture, up to a maximum fee allowance for a standard denture. The patient is responsible for the portion of the dentist's fee in excess of this allowance for any denture and/or related service.
d) Removable temporary partial dentures are a benefit only when anterior teeth are missing. An allowance limited to the covered amount for a removable appliance may be made toward the cost of the other procedures performed. The patient is responsible for the portion of the dentist's fee in excess of the Delta Dental allowance.
e) Benefit based on the cost of a covered complete or removable partial denture may be made toward the cost of implants and appliances constructed in association therewith. If benefit is made for such an appliance, benefit will not be made for any replacement within five (5) years thereafter.
f) Benefit for reline or rebase of a prosthodontic appliance will be made only once in any three (3) year period.
g) Fixed bridges and/or cast metal framework partial dentures are not a benefit for persons under age sixteen (16).

IV. ORTHODONTIC SERVICES

The procedures associated with oral surgery or appliance therapy for movement and post-treatment retention of teeth and/or jaws, into proper alignment, position and occlusion including any related diagnostic, preventive or interceptive services except extraction of teeth.

Limitations On Orthodontic Benefits

a) Replacement or repair of appliances is not a benefit.
b) Orthodontic care provided in the treatment of periodontal cases or cases involving treatment or repositioning of the temporomandibular joint or related conditions is not a covered service.
c) The obligation of the Plan to make periodic payments for an Orthodontic treatment plan shall cease upon termination of treatment for any reason prior to completion of the case.
d) The obligation of the Plan to make periodic payments for an Orthodontic treatment plan begun prior to the eligibility date of the patient shall commence with the first payment due following the patient's eligibility date. The amount payable (Lifetime Orthodontic Benefit Maximum) will apply fully to this and subsequent payments.
e) The obligation of Delta Dental to make periodic payments for an Orthodontic treatment plan shall cease upon termination of the covered person's eligibility.
f) Extended coverage provisions do not apply to Orthodontic services.

General Limitations - All Services

a) If a covered person selects a service that is not a benefit or selects a specialized technique instead of a standard service, Delta Dental will pay the applicable percentage of the fee for the least costly commonly performed covered service and the patient is responsible for the remainder of the dentist's fee.
b) Services involving veneers, facings, or any other cosmetic services posterior to the first molar are considered optional and are not a benefit. An allowance may be made for the covered amount of the covered service without veneers, facings or cosmetic components. The patient is responsible for the portion of the dentist's fee in excess of the Delta Dental allowance.
c) Pre- and post-operative procedures are considered part of any covered service and are not benefits. Benefit shall be limited to the covered amount for the covered service.
d) Local anesthesia is considered a component of any procedure in which it is used.
e) Allowance for covered services started but not completed shall be limited to the amount determined by Delta Dental.
f) A temporary dental service will be considered an integral part of a complete dental service rather than a separate service, and separate payment shall not be made for a temporary service unless otherwise included as a covered service.
g) Allowance for an assistant surgeon when determined by Delta Dental to be a covered benefit shall not exceed 20% of the surgeon's fee for the same covered service.

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 eligible person by any federal or state government agency or are provided without cost to the eligible person by any municipality, county or other political sub-division, or any services for which the eligible 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 during any period when the person was not eligible for such service.
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 or for any services related to protecting, altering, correcting, stabilizing, rebuilding or maintaining teeth due to improper alignment, occlusion or contour or for splinting or stabilization of teeth.
f) Habit appliances, and gnathological (jaw function) services, bite registration or analysis, or any related services.
g) Pre-medication, analgesia, hypnosis or any other patient management services.
h) Charges for prescription drugs.

i) Experimental procedures, or any procedures other than those covered services for which the prognosis is good (as defined by Delta Dental). Any procedures done in anticipation of future need (except covered preventive services).
j) Hospital costs and any additional fees charged by the dentist or hospital for hospital services, visits, or charges for use of any facility.
k) Anesthesia other than general anesthesia, intravenous sedation or analgesia administered in connection with covered oral surgery services as provided for in the Master Contract.
l) Extraoral grafts (grafting of tissues or other substances from outside the mouth to or into oral tissues), augmentations or implants and/or any associated appliances. Removal of implants or any services associated therewith.
m) Myofunctional therapy or speech therapy.
n) Services for the treatment of any disturbances of the temporomandibular joint (jaw joint), facial pain, or any related conditions, including any related diagnostic, preventive or interceptive services.
o) Services not performed in accordance with the laws of the State of Colorado, 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.
p) Oral hygiene instructions or dietary instructions.
q) Completion of forms, providing diagnostic information or records, or duplication of x-rays or other records.
r) Replacement of lost, stolen or damaged appliances.
s) Any services not specifically included as covered.
t) Services for which payment is prohibited by any law of the jurisdiction in which the eligible person resides at the time the expenses are incurred.
u) Services for which charges would not have been made if this coverage had not existed, except for services as provided under Medicaid.

COORDINATION OF BENEFITS

Warning: If You are insured under a separate group medical or dental insurance policy or plan, You may be subject to coordination of benefits as explained in this booklet.

If You are entitled to coverage under two or more plans, then the benefits of this Plan shall be coordinated with other plan benefits.

- Plan means any plan providing dental care benefits under group, blanket or franchise coverage; or service type plans or other group pre-paid plans; or coverage under any governmental plan or required by law; or "No-Fault" motor vehicle insurance.
- Primary coverage is the coverage that has the first responsibility for paying a claim. The primary coverage must pay up to its full liability.
- Secondary coverage is the coverage responsible for paying a claim after the primary coverage has paid up to its full liability.

Order of benefit determination if the other coverage is by a dental insurance policy or prepaid dental care program:

a) The policy or program covering the patient as an employee shall be primary over the policy or program covering the patient as a dependent;
b) For dependent children's expenses the order of benefit determination shall be as follows:
   i. The policy of the parent whose birthday (excluding year of birth) occurs earlier in a year shall be primary, or;
   ii. If the parents are separated or divorced, the policy of the parent who is ordered by court decree to take financial responsibility for dental expenses shall be primary, or;
   iii. The policy of the parent with custody is primary and if said parent has remarried, the step-parent's plan is secondary and the plan of the parent without custody pays third.
c) If the above rules do not establish an order of benefit determination, the plan that has covered the person for the longer period of time shall be primary with the following exception that the plan covering the person as a laid-off or retired employee or dependent of such person shall be determined after the benefits of any other plan covering the person or employee.
d) Any group plan that does not contain a coordination of benefits provision is automatically primary.

The State of Colorado has a non-duplication of benefits clause in their dental plans. Non-duplication of benefits means the Plan will not duplicate any benefit it would have normally paid were it the primary insurance. With non-duplication (also known as "Carve Out") the Plan will subtract the benefits paid by the primary insurance carrier from the benefits that the Plan would have normally paid (benefits less benefits). If a balance remains, the Plan will pay that amount.

Example #1:

Total charge: $500.00
The Plan would normally pay 50% or $250.00
Primary insurance paid $250.00
Subtract the amount the primary insurance paid from the amount the Plan would have normally paid. ($250.00 less $250.00 = $0). The benefit to be paid by the Plan as the secondary carrier is $0.

Example #2:

Total charge: $500.00
Delta Dental would normally pay 50% or $250.00
Primary insurance paid $200.00
Subtract the amount the primary insurance paid from the amount Delta Dental would have normally paid. ($250.00 less $200.00 = $50.00) The benefit to be paid by Delta Dental as the secondary carrier is $50.00.

If the Plan is primary as provided above, the Plan shall provide benefits without regard to benefits provided by any other plan. If the Plan is secondary and the Plan Year maximum has been reached by the primary carrier, the Plan would then begin to pay as if it were the primary carrier (or until the Plan Year Benefit Maximum is reached or the Plan Year ends, whichever comes first).

DENTAL HEALTH INFORMATION DISCLOSURE

The Administering Company cannot release Your dental information without Your written consent. That information is strictly confidential. However, there are some exceptions:

- information necessary for treatment, payment or dental plan operations,
- information that is requested for utilization summaries or reviews given to Your Employer, since Your Employer funds all or part of the cost of Your claims
- peer and utilization review boards and the Administering Company's dental consultants need the information to ensure that You are getting the necessary Covered Services for dental
- there is a court order for the information
- the Colorado Division of Insurance requests the information
- the information is required for:
  - third-party liability (subrogation) proceedings
  - coordination of benefits

Except as required by applicable law, the Administering Company cannot release to You any information that a Dentist gave to the Administering Company, unless it has the Dentist's written consent.

EXTENDED COVERAGE
(Extension of Benefits)

If eligibility is terminated, the Plan will pay for services that were started prior to the date of termination. The extended coverage will not exceed sixty (60) days and applies only to single covered services that are fixed or removable prosthodontic appliances, crowns, jackets, cast, fused or other laboratory processed restorations and were installed or seated within sixty (60) days after termination of coverage. **This provision does not apply to Orthodontic Services.**

INTERNAL APPEAL OF CLAIMS

Internal Appeal Process - First Level Appeals

Questions concerning the action taken on a claim can be directed to the Customer Service Department of Delta Dental of Colorado for clarification. If the explanation is not acceptable, You may appeal the determination by writing to the Appeals Analyst of Delta Dental within 180 days after receiving a written denial. Any written communication should include documents or records in support of Your claim.

Send Your appeal request to:

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

Appeal requests will be reviewed by a Dentist who shall consult with an appropriate clinical peer, unless the reviewing dentist is a clinical peer of the treating dentist. The Dentist and the clinical peer will not have been involved in the initial adverse determination.

A written appeal decision will be issued to the Member and designated Dentist(s) that explains the decision and the rationale for the decision. The appeal decision will be issued within 30 calendar days after receipt of the appeal request.

Internal Appeal Process - Second Level Appeals

If the member is not satisfied with outcome of the First Level Appeal, in certain cases, a Second Level Appeal may be available. If so, the Appeals Analyst will advise the member of their second level appeal rights.

A second level appeal request must be received within 30 days of the First Level Appeal decision and must be submitted to the address noted above. Additional documentation supporting the Second Level Appeal request may be submitted. This appeal will be evaluated by a review panel consisting of three people, two of whom are Dentists. The appeal panel will not have been involved in the case previously. The Member, or a designated representative, may request to appear before the review panel either in person or by conference call.

A Second Level Appeal decision will be issued within 7 days of the date of the review panel's decision.

INDEPENDENT EXTERNAL REVIEW

If a request for coverage is denied based on medical necessity, and a Member remains dissatisfied with the outcome of the Second Level Appeal decision (when available), an Independent External Review may be requested. Requests must be received in writing within 60 days of the Second Level Appeal decision and addressed to the Appeals Analyst at the address above. Requests must include a completed extended review request form from the Division of Insurance and a signed consent authorizing Delta Dental to disclose protected health information pertinent to the external review.

The Subscriber will be notified of the External Review Decision within 1 day of its receipt by Delta Dental.

PAYMENTS MADE IN ERROR

Should the Plan make a payment in error, the Plan has the right to recover the payment from the Covered Person or Dentist. If the Plan recovers payment from the Dentist, the Dentist may have the right to recover payment from You. The Plan can also recover incorrect payment amounts by paying less on future claims and/or taking legal action.

If the Plan is required to take any legal action to uphold its rights and it prevails, You are required to pay the Plan's legal expenses and Your own, including attorney fees and court costs.

LEGAL COMPLIANCE AND IMPORTANT NOTICES

This section contains important notices that are required to be given to Members covered under the Plan.

Authority of the Plan Administrator

The Plan Administrator is the Claims Administrator for this Plan including any managed care appeals. The Plan Administrator is:

Colorado Dental Service Inc., d.b.a. Delta Dental of Colorado
4582 S. Ulster St., Suite 800
Denver, CO 80237

If You have any questions about Your Plan, You should contact the Plan Administrator's Customer Service at 1-800-489-7168. The Plan Administrator is the entity designated for service of legal process.

The Plan Administrator is also the Plan fiduciary. The Plan Administrator has the sole and absolute discretion to interpret the terms of the Plan and determine the right of a Member to receive benefits under the Plan. The Plan Administrator's decision shall be final, conclusive and binding upon all participates.

The State's Right

The State reserves the right to add, modify or discontinue the State benefit plans as deemed necessary.

Funding and Compliance with Applicable Law

The State of Colorado sponsors the Employee Group Dental Plan for Eligible Employees and their Dependents. The Dental Coverages provided under the Plan as described in this Summary are funded and provided by the **STATE OF COLORADO**. Effective July 1, 2005, the Plan is self-funded.

The Plan is not subject to regulation by the Colorado Division of Insurance since the Plan is self-funded. The Employee Benefits Act, C.R.S. 24-50-605(f) requires that any benefit plan comply with the mandated coverages required by C.R.S. 10-16-104. The Plan is a governmental plan and exempt from complying with the requirements of the Employee Retirement Income Security Act (ERISA) and COBRA, however, the Plan is subject to the continuation of coverage rules under the Public Health Services Act (PHSA). References in this Summary to COBRA shall mean and include continuation of coverage under the PHSA.

HIPAA Portability Rules

The Plan is required to comply with the portability and special enrollment rules of the Health Insurance Portability and Accountability Act (HIPAA). Refer to the Special Enrollment provisions in the Eligibility section of this Summary. When You or a covered Dependent terminates coverage under the Plan, the Plan will send You a certificate of coverage that identifies the length of coverage under the Plan. The HIPAA Certificate of Coverage may be needed if You enroll in another dental plan that imposes a pre-existing condition waiting period.

HIPAA Privacy & Security

The Plan is subject to federal privacy rules and restrictions under the Health Insurance Portability and Accountability Act (HIPAA) regarding use and disclosure of protected health information. Generally, these rules and restrictions provide Plan Participants with certain protections and rights against improper use and disclosure of protected health information. In order to provide You with information regarding Your privacy rights with respect to protected health information, the Plan is required to provide You with a notice describing the Plan's privacy practices and other required information. This notice is provided to all new Plan Participants at time of enrollment and to all Plan Participants within 60 days of any material revision of the notice. The HIPAA Notice of Privacy Practices is included at the back of this Summary Plan Description. Copies of the notice will also be available at all times at the State Employee Benefits Unit.

The Plan is subject to HIPAA rules and restrictions regarding the security of electronic protected health information. These security provisions require the Plan to implement administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of electronic protected health information.

VERY IMPORTANT NOTICE

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because You have recently become covered under a group health plan (the Plan). This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You when You would otherwise lose Your group health coverage. It can also become available to other members of Your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about Your rights and obligations under the Plan and under federal law, You should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, Your spouse, and Your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You are an employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from Your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of

employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), You must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice following the Reasonable Notice Procedures, as described below.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), Your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, You and Your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Notice of this disability must be given following the Reasonable Notice Procedures described below.

Second qualifying event extension of 18-month period of continuation coverage

If Your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Notice of the second qualifying event must be given following the Reasonable Notice Procedures described below.

Reasonable Notice Procedures

Any notice that needs to be provided must be in writing. Oral notice, including notice by telephone, is not acceptable. You or Your spouse or dependent must mail the notice to the contact person at the address specified below under Plan Contact Information.
The notice must be postmarked no later than the last day of the required notice period. Any notice You provide must state the name and address of the Employee covered under the Plan and the names and addresses of the Qualified Beneficiaries, the Qualifying Event and the date it happened. If a Qualifying Event is a divorce, the notice must include a copy of the divorce decree. The notice must be provided by the Qualified Beneficiary, spouse or parent, if applicable or by an Authorized Representative of the Qualified Beneficiary.

Keep Your Plan Informed of Address Changes

In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members. Notice of changes of addresses of family members should be mailed in writing to the Plan Administrator to the address specified below under Plan Contact Information. You should also keep a copy, for Your records, of any notices You send to the Plan Administrator.

Plan Contact Information

Employee Benefits Unit – COBRA Coordinator
Colorado Department of Personnel & Administration
Division of Human Resources
1313 Sherman Street, First Floor
Denver, CO 80203

Delta Dental of Colorado Contact Information

If You have any questions about this notice or Your rights to COBRA continuation coverage, You may contact:
Delta Dental of Colorado
4582 S. Ulster St., Suite 800
Denver CO 80237
The telephone number is 1-800-489-7168.

If You Have Questions

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contacts identified in this notice.

The State of Colorado reserves the right to add, modify or discontinue the State group benefits plans as deemed necessary. The State of Colorado Employee health plan is controlled by contracts, rules and statutes. In the event of a conflict between this Summary and the governing laws or regulations, the governing laws or regulations will prevail.

It is unlawful for any employee or dependent to provide false, incomplete or misleading facts or information on any state group benefit enrollment form, affidavit, claim or other document for the purpose of defrauding or attempting to defraud the State of Colorado or the Plan. Any employee or dependent who provides false, incomplete or misleading facts or information on any document shall be reviewed by the Director. If the Director has reasonable suspicion to believe that an employee or dependent has defrauded or attempted o defraud any state group benefit plan, coverage shall be terminated, and the employee or dependent may be denied future enrollment and may be subject to other action.

HIPAA NOTICE OF PRIVACY PRACTICES

Effective July 1, 2005

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.

The Colorado Department of Personnel and Administration (DPA) understands the importance of keeping Your medical information private and secure. When we use the terms "medical information" or "health information" in this notice, we mean personal information that would allow You to be identified and that relates to health care services provided to You; the payment of health care services provided to You; or Your past, present, or future physical or mental health. The terms "we," "us," and "our" in this notice refer to the following State of Colorado Group Health Plans: Great-West Healthcare PPO-1500, PPO-3500, PPO-H, INO-30, and INO-40; Delta Dental Basic, Basic Plus, and Direct Reimbursement; and healthcare flexible spending account. The group health plans do not have employees. They are administered by DPA employees and third party administrators.

This notice explains how we use Your health information and when we can share that information with others. It also informs You of Your rights with respect to Your health information and how You can exercise those rights. We are required to follow the terms of this notice until the notice is replaced. We reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. Once revised, we will provide You with a copy of the new notice.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

Federal law allows us to use or disclose protected health information without Your authorization for the purposes of treatment, payment, and health care operations.

Treatment: We may use and disclose information when communicating with Your doctors to help them provide medical care to You. For example, we might suggest to Your doctor a disease management or wellness program that could improve Your health.

Payment: We may use and disclose information about You so that the medical services You receive can be properly billed and paid. For example, we may need to give Your insurance information to health care providers so they can bill us for treating You.

Operations: We may use and disclose information about You for our business operations. For example, we may disclose information about You to consultants who provide legal, actuarial, or auditing services. We will not disclose Your health information to outside groups unless they agree in writing to keep it protected.

We may also use or disclose Your health information for other health-related benefits and services. For example, we may send You appointment reminders or information about programs that may be of interest to You, such as smoking cessation or weight loss.

There are also state and federal laws that may require or allow EBU to use or disclose Your health information without Your authorization. The examples below are provided to describe generally the ways in which we may use or disclose Your information.

- To state and federal regulatory agencies.
- For public health activities.
- To public health agencies if we believe there is a serious health or safety threat.
- With a health oversight agency for certain activities such as audits and examinations.
- To a court or administrative agency pursuant to a court order or search warrant.
- For law enforcement purposes.
- To a government authority regarding child abuse, neglect, or domestic violence.
- With a coroner or medical examiner, or with a funeral director.
- For procurement, banking or transplantation of organs, eyes, or tissue.

- For specialized government functions, such as military activities and national security.
- Due to the requirements of state worker compensation laws.

For us to use or disclose Your health information for any reason other than those identified in this section ("How We May Use or Disclose Your Health Information"), we must get written authorization from You. You may revoke the authorization at any time, but Your revocation must also be in writing. The revocation will not affect any uses or disclosures consistent with the authorization made prior to receipt of the revocation by DPA's HIPAA Compliance Officer.

YOUR RIGHTS

The following are Your rights with respect to Your health information.

You have the right to ask us to restrict how we use or disclose Your information for treatment, payment, or health care operations. All requests must be made in writing and state the specific restriction requested. We will try to honor Your request, but we are not required to agree to a restriction.

You have the right to ask to receive confidential communications of information. For example, if You believe You would be harmed if we send information to Your current mailing address (for example, in situations involving domestic disputes or violence), You can ask us to send the information by alternative means (for example, by telephone) or to an alternative address. We will accommodate a reasonable request if the normal method or disclosure could endanger You and You state that in Your request. Any such request must be made in writing.

You have the right to inspect and obtain a copy of information that we maintain about You in Your designated record set. A "designated record set" is a group of records that may include enrollment, payment, claims adjudication, and case or medical management records. *However, You do not have the right to access certain types of information* such as psychotherapy notes and information compiled for legal proceedings. If we deny Your request, we will notify You in writing and may provide You with a right to have the denial reviewed.

You have the right to ask us to amend the information we maintain about You in Your designated record set (as defined above). Your request must be made in writing and You must provide a reason for the request. If we agree to Your request, we will amend our records accordingly. We will also provide the amendment to any person that we know has received Your health information from us, and to other persons identified by You. If we deny Your request, we will notify You in writing of the reason for the denial. Reasons may include that the information was not created by us, is not part of the designated record set, is not information that is available for inspection, or that the information is accurate and complete.

You have the right to receive an accounting of certain disclosures of Your information made by us during the six years prior to Your request, but no earlier than July 1, 2005. We are not required to account for certain disclosures, such as disclosures made for purposes of treatment, payment, or health care operations, and disclosures made to You or authorized by You. Your request must be made in writing. Your first accounting in a 12-month period will be free. We may charge You a fee for additional accountings made within 12 months of the free accounting. We will inform You in advance of the fee and provide You with an opportunity to withdraw or modify Your request.

You have a right to receive a copy of this notice upon request at any time.

CONTACTS

For further information, to exercise Your rights, or if You believe Your privacy rights may have been violated and You want to file a complaint, please contact DPA's HIPAA Compliance Officer by U.S. mail or by e-mail, as follows:

U.S. Mail: HIPAA Compliance Officer
Colorado Department of Personnel and Administration
Division of Human Resources
1313 Sherman Street
Denver, CO 80203

e-mail: dpahipaacompliance@state.co.us

You may also notify the Secretary of the U.S. Department of Health and Human Services of Your complaint.

No action will be taken against You for exercising Your rights or for filing a complaint.