

Dental Benefit Handbook

Delta Dental of New Mexico

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

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

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

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

This Handbook, along with all supporting documentation and lists of Delta Dental Participating Providers, is always available at www.deltadentalnm.com. Please take time now to become familiar with your dental coverage. For answers to questions about Benefits, please call:

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

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

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I. Eligibility, Enrollment and Effective Dates

UNM will determine who is eligible to enroll based on current UNM policies, procedures, and employment practices. To be eligible for Covered Services you must be enrolled as a Participant. To be eligible as a Participant, you must meet either the Employee or Dependent eligibility criteria listed below.

You must enroll within 60 calendar days from your date of eligibility, or during Open Enrollment. Late enrollments are not accepted. Mid-year enrollments are only allowed when you experience a permitted Qualifying Change in Status.

Initial Enrollment

- A. Coverage begins the first of the month following the date of enrollment. You are not eligible for benefits before your date of hire or date of eligibility.

Late Enrollments Not Accepted
If you fail to enroll yourself/dependents within the initial eligibility period, you will not be able to enroll unless you experience a qualifying change in status, or until Open Enrollment, which is in the spring. Enrollment during Open Enrollment will not become effective until July 1 of that year.

EMPLOYEE ELIGIBILITY CRITERIA	
YOU BECOME ELIGIBLE ON THE FIRST DAY YOU ARE EMPLOYED IN A BENEFITS ELIGIBLE POSITION	
Staff	<ul style="list-style-type: none"> ▪ Regular full-time or part-time employees ▪ Appointment percent of 50% or greater
Temporary Staff	<ul style="list-style-type: none"> ▪ At least three-month appointment ▪ Appointment of 75% or greater
Faculty	<ul style="list-style-type: none"> ▪ At least three-month contract ▪ Full-time or part-time employees ▪ Appointment percent of 50% or greater
Adjunct Faculty	<ul style="list-style-type: none"> ▪ At least three-month contract ▪ Appointment of 75% or greater
Term Employee	<ul style="list-style-type: none"> ▪ Minimum term of 3 months ▪ Appointment percent of 50% or greater
Post-Doctoral Fellow	<ul style="list-style-type: none"> ▪ At least three-month contract ▪ Regular full-time or part-time employees ▪ Appointment percent of 50% or greater

EMPLOYEE ELIGIBILITY CRITERIA	
YOU BECOME ELIGIBLE ON THE FIRST DAY YOU ARE EMPLOYED IN A BENEFITS ELIGIBLE POSITION	
UNM Affiliates	Employees of the UNM Affiliate Employers UNM Hospitals, UNM Medical Group, and STC.UNM
Joint Appointment Employees	Employees, as determined by UNM, who are employed through a joint appointment with any Federal or State agency
Retirees	UNM approved Retirees and dependents

Dependent Enrollment

- Dependent(s) are eligible for enrollment to your coverage provided you submit the necessary proof documentation.
- Initial dependent enrollment must be within 60 days of your eligibility date (ideally at the same time as you enroll). Otherwise, you may be able to add dependents outside of an enrollment period when you experience a Qualifying Change in Status or Special Enrollment event.
- Documentation supporting dependent eligibility, such as a valid marriage certificate, birth certificate, or Affidavit of Domestic Partnership, must be provided.

NOTE: HR Benefits may request documents supporting dependent eligibility at any time. Documents supporting dependent eligibility must be provided when requested. Failure to provide proof of dependent eligibility may result in the cancellation of dependent coverage, and UNM may seek reimbursement of associated paid claim costs.

Surviving Spouse Coverage

- Surviving spouses of employees who were active at the time of death are eligible to continue coverage for twelve (12) months after the employee's death as long as the applicable premium is paid. UNM will continue premium contributions based on the employee's salary and appointment percent prior to death. After the twelve (12) month period, coverage may be continued through COBRA provisions.
- Surviving dependent children can only continue coverage for the twelve (12) month period after the death of an active employee if he or she is covered as a dependent of a surviving spouse, as long as he or she continues to meet dependent eligibility criteria. Dependent children may continue through COBRA provisions at the end of the twelve (12) month period, or when he or she loses dependent eligibility, whichever is earlier.
- Surviving spouses of retirees are eligible to continue coverage as long as the applicable premium is paid. UNM will continue premium contributions for surviving spouses for twelve (12) months following the death of a retiree at the same contribution rate prior to the retiree's death. After twelve (12) months, the surviving spouse may remain covered by the Plan by paying 100% of the total premium.
- Surviving dependent children of a retiree may continue coverage only if he or she is covered as the dependent of a surviving spouse of a retiree, as long as he or she continues to meet dependent eligibility criteria. UNM will contribute to the premium for eligible surviving

dependent children for twelve (12) months or until he or she no longer meets eligibility criteria. After twelve (12) months, if the dependent child still meets eligibility criteria, he or she may remain covered by the plan until he or she is no longer eligible provided the surviving spouse pays 100% of the premium for the dependent child. After the dependent child is no longer eligible, he or she may continue under COBRA provisions.

Family Status or Employment Status Changes

To enroll in coverage and/or add dependents after initial enrollment or outside of an Open Enrollment period, you or your dependents must meet the criteria for a “Qualifying Change in Status” or “Special Enrollment.” If criteria are not met, dependents are not eligible for enrollment until Open Enrollment in the spring.

Special Enrollment

If you chose not to enroll in the Plan during a previous enrollment period but are otherwise eligible for Coverage, you may enroll in the Plan due to a Special Enrollment Event. Enrollment must be completed within 60 calendar days of acquiring a new Dependent through marriage, birth, adoption or placement for adoption. Special Enrollment applies to the Participant, spouse, and other eligible Dependents including new Dependents acquired because of the marriage, or newborn/adopted children who triggered the event.

Event	Effective date of enrollment
Marriage	Beginning of the Month Following Enrollment
Birth of a Child	Date of Birth
Adoption or Placement for Adoption	Date of Adoption or Placement for Adoption

CHIPRA (in accordance with provisions as currently may be defined under federal law)

- If you chose not to enroll in the Plan for self and/or dependent(s) during a previous enrollment period because you and/or your dependents were covered under a state Medicaid or Children’s Health Insurance Program (CHIP) plan and such coverage terminated due to a loss of eligibility, you may enroll in coverage for self and/or any affected eligible Dependent(s), if the Dependent is eligible provided you enroll within 60 calendar days from the date Medicaid or CHIP coverage terminated.
- If you chose not to enroll in the Plan for self and/or dependent(s) coverage during a previous enrollment period and have become eligible for group health premium assistance under State Medicaid or State CHIP, you may enroll in coverage for self and/or eligible Dependent(s) provided you enroll within 60 days of becoming eligible.
- If you apply within 60 days of the date Medicaid or CHIP coverage is terminated or within 60 days of the date the employee is determined to be eligible for employment assistance under a state Medicaid or CHIP plan, coverage will start no later than the first day of the month following receipt of your enrollment request.

Qualifying Change in Status Event

Notwithstanding the provisions specified in “Special Enrollment” of this Section, you may make certain changes to your benefit elections within 60 calendar days of a Qualifying Change in Status Event. Evidence of the change in status must be provided with your enrollment in order to change your benefit elections. Any change in coverage will become effective on the first day of the month following enrollment. The only exceptions are birth and adoption, where the additional coverage is effective retroactively to date of birth or adoption as long as enrollment is

received within 60 calendar days from the event. Termination of a Dependent is not a qualifying event for you to change benefit plans.

Documents supporting dependent eligibility must be provided when requested. Additionally, UNM will require documentation supporting the Qualifying Change in Status Event. Failure to provide documents supporting dependent eligibility or the Qualifying Change in Status Event when requested may result in the cancellation of dependent coverage, and UNM may seek reimbursement of associated paid claim costs.

Qualifying Change in Status Event Required Support Documentation

Note: Documentation supporting the Qualifying Change in Status Event must be submitted to HR Benefits. If enrolling dependents, documentation supporting dependent eligibility is also required at the same time.

The list below is not all-inclusive.

Your or Your Spouse's Unpaid Leave of Absence

- Documentation supporting the effective date of the unpaid leave of absence. The change must be consistent with the event.

Marriage

- Marriage Certificate
- Birth Certificate (If adding any child of the newly acquired spouse)

Divorce or Legal Separation

- Divorce - Final Divorce Decree
- Legal Separation - Court Filed Legal Separation Documentation

Birth of a Child

- Birth Certificate of Biological Child
- If a Birth Certificate is not available for newborn children, proof of birth from the provider/hospital listing both parents and date of birth is acceptable.

Coverage for the child will be effective retroactively to the date of birth, provided you enroll the newborn within 60 Calendar Days from the date of birth.

Adoption or Placement for Adoption

- Official court/agency placement documentation for a child placed with you for adoption
or
- Official Court Adoption Agreement for an adopted child, or Birth Certificate
Coverage for the child will be effective retroactively to the date of adoption or placement for adoption, provided you enroll the child within 60 Calendar Days from the date of adoption or placement for adoption.

The term "placement" as used in this paragraph means the assumption and retention of a legal obligation for total or partial support of the child in anticipation of adoption of the child. Such child shall continue to be eligible for coverage unless placement is disrupted prior to legal adoption. Placement terminates or is disrupted when the legal obligation terminates.

Death of a Spouse or Dependent Child

Qualifying Change in Status Event Required Support Documentation

Note: Documentation supporting the Qualifying Change in Status Event must be submitted to HR Benefits. If enrolling dependents, documentation supporting dependent eligibility is also required at the same time.

The list below is not all-inclusive.

- Death Certificate

Change in Spouse's Employment Resulting in the Gain or Loss of other Health Care Coverage

- Documentation supporting the gain or loss of other coverage. The documentation must provide the effective date of new coverage and the type of coverage (medical, dental, etc.).

Gain or Loss of Other Health Care Coverage

- Documentation supporting the gain or loss of other coverage. The documentation must provide the effective date of new coverage and the type of coverage (medical, dental, etc.).

Change in Legal Responsibility for a Dependent Child

- Official court documentation requiring you to provide coverage for an eligible dependent child or releasing you from legal responsibility for the dependent child.

Dependent Child Attains Age 26

- Coverage will terminate at the end of the month that the child turns 26

Continuation of Disabled Child Over Age 26

- UNM Child Disability Affidavit signed by the employee and the child's physician.

Note: To be eligible, the disabled dependent must be enrolled in coverage prior to age 26

II. How the UNM Dental Plan Works

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

The UNM dental plan offers you multiple choices and options which will save you on out-of-pocket costs. We know that choice and savings are two things you value in your dental plan-and the UNM plan has both.

The UNM dental plan is unique because it features two different Delta Dental provider networks — two “in-network” choices in a single plan. Delta Dental PPOSM dentists have agreed to the most deeply discounted Maximum Approved Fees of any Delta Dental network. The Delta Dental Premier® network is also offered for individuals who prefer a dentist who only participates in that network.

Co-insurance levels are the same in both networks but the choice of dentists makes a difference in a patient’s out-of-pocket costs at the time services are received. Non-participating dentist do not accept Delta Dental’s Maximum Approved Fees. In addition to any copayment, deductible, and fees for non-covered services, you will also be responsible for any difference between the dentist’s submitted charge and the Maximum Approved Fees.

	Low Option Networks:		
	Delta Dental PPO	Delta Dental Premier	Non-Participating
Participates with Delta Dental in the Low Option Plan?	Yes	Yes	No
Out-of-Pocket Costs for the Low Option Plan:	Lowest	Higher than Delta Dental PPO	Highest
Delta Dental Pays Up To:	Delta Dental PPO Maximum Approved Fees	Delta Dental PPO Maximum Approved Fees	Delta Dental’s Non-Participating Maximum Approved Fees
Provider May Balance Bill You?	No	Yes, up to the Delta Dental Premier Maximum Approved Fees	Yes, up to the Provider’s Submitted Amount

Low Option Plan Description of Out-of-Pocket Costs:

Delta Dental PPO

You will be responsible for any Coinsurance and Deductible (if applicable) for Covered Services up to the Delta Dental PPO Maximum Approved Fees. You are also responsible for the full payment for any non-covered services.

Delta Dental Premier

In addition to any Coinsurance, Deductible (if applicable), and fees for non-covered services, you will be responsible for the difference between the Delta Dental PPO Maximum Approved Fees and the Delta Dental Premier Maximum Approved Fees, when selecting a Delta Dental Premier provider.

Non-Participating Provider

In addition to any Coinsurance, Deductible (if applicable), and fees for non-covered services, you will be responsible for any difference between Delta Dental's Non-Participating Maximum Approved Fees and the Provider's Submitted Amount.

Subscribers are responsible for full payment to a Non-Participating Provider. Any payment made by Delta Dental for services received from a Non-Participating Provider may be paid to the Provider or directly to the Subscriber.

	High Option Networks:		
	Delta Dental PPO	Delta Dental Premier	Non-Participating
Participates with Delta Dental in the High Option Plan?	Yes	Yes	No
Out-of-Pocket Costs for the High Option Plan:	Lowest	Higher than Delta Dental PPO	Highest
Delta Dental Pays Up To:	Delta Dental PPO Maximum Approved Fees	Delta Dental Premier Maximum Approved Fees	Delta Dental's Non-Participating Maximum Approved Fees
Provider May Balance Bill You?	No	No	Yes, up to the Provider's Submitted Amount

High Option Plan Description of Out-of-Pocket Costs:

You will have the lowest out-of-pocket costs when you select a Delta Dental PPO Provider. Delta Dental Premier Providers who participate in the PPO Provider network have agreed to accept the Delta Dental Premier Maximum Approved Fees.

Delta Dental PPO

You will be responsible for any Coinsurance and Deductible (if applicable) for Covered Services up to the Delta Dental PPO Maximum Approved Fees. You are also responsible for the full payment for any non-covered services.

Delta Dental Premier

You will be responsible for any Coinsurance and Deductible (if applicable) for Covered Services up to the Delta Dental Premier Maximum Approved Fees. You are also responsible for the full payment for any non-covered services.

Non-Participating Provider

In addition to any Coinsurance, Deductible (if applicable), and fees for non-covered services, you will be responsible for any difference between Delta Dental's Non-Participating Maximum Approved Fees and the Provider's Submitted Amount.

Subscribers are responsible for full payment to a Non-Participating Provider. Any payment made by Delta Dental for services received from a Non-Participating Provider may be paid to the Provider or directly to the Subscriber.

Claims

All Delta Dental Participating Dentists will submit your dental claims to Delta Dental for processing. Delta Dental will send payment, on behalf of the Plan, directly to Delta Dental dentists.

When making an appointment, confirm that the dentist participates in your specific Delta Dental network(s) referenced in the Summary of Dental Plan Benefits in order to minimize your out-of-pocket expenses.

For online access to New Mexico provider directories, or to search for a dentist nationally, visit the website at www.deltadentalnm.com and click on the Find a Dentist link. For assistance, members may also contact:

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

III. Accessing Your Benefits

A. General Information About Selecting a Provider

1. Your Summary of Dental Plan Benefits, available at <https://hr.unm.edu/benefits/dental>, contains specific information about your dental Plan's network(s).
2. You will have the lowest out-of-pocket costs when you select a Provider who participates in the network specified at the top of your Summary of Dental Plan Benefits.
3. Delta Dental does not require that you pre-select a Provider and does not guarantee that a particular Provider will be available.
4. Search for Participating Providers on www.deltadentalnm.com. The search feature allows you to find Providers in New Mexico or nationally, based on network, specialty, last name, and/or location.
5. Each Plan Participant in your family may choose a different Provider.

6. You are responsible for the full payment for any non-covered services.

B. Accessing Benefits

To use this Plan, follow these steps:

1. Read this Handbook and the Summary of Dental Plan Benefits carefully to become familiar with your Benefits, network(s), Delta Dental's method of payment on behalf of the Plan, and the provisions of this Plan.
2. Make a dental appointment and tell the dental office that dental coverage is under this Plan. If the office is not familiar with the coverage applicable to this Plan or has questions regarding this Plan, the dental office may contact the Delta Dental Customer Service Department at (505) 855-7111 or toll-free (877) 395-9420.
3. Following dental treatment, a claim needs to be filed with Delta Dental. All Delta Dental Participating Providers will file the claim directly with Delta Dental. Non-participating providers may require patients to file their own claims. Claims for Benefits must be submitted to Delta Dental in writing within twelve (12) months from the date services were provided. Failure to submit a claim within the time limitation shall not void or reduce the claim if it is shown it was not reasonably possible to submit within the twelve (12) months. Delta Dental will make the final determination.
4. Plan Participants are responsible for filing claims for services received from a non-participating provider, including providers outside of the United States. A claim form, including the "Patient Section," must be completed. Prior to submission to Delta Dental, the dental office providing services must complete an itemization of services that includes the name of the clinic and Provider, tooth number, if applicable, a description of each individual service, a date of service, a fee for each individual service, and a signature by the Provider. Upon review of any out-of-country claims, Delta Dental may respond to you with a letter requiring your signature acknowledging you received the specified dental services.

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

If the services performed outside of the United States are for extractions, crowns, bridges, dentures, or partial dentures, a radiographic image of the area must be obtained prior to the service being considered for Benefits. Plan Participants are responsible for obtaining the necessary documentation for services provided, for filing a claim with Delta Dental, and for payment to the Provider at the time services are performed.

Delta Dental will calculate foreign currency Benefit payments based on published currency conversion tables that correspond to the date of service.

5. Completed claim forms should be submitted to Delta Dental, 2500 Louisiana Boulevard N.E. Suite 600, Albuquerque, New Mexico, 87110. The Delta Dental Customer Service Department is available Monday through Friday, 8:00 a.m. – 4:30 p.m. (Mountain Time) at (505) 855-7111 or toll-free (877) 395-9420.
6. Within thirty (30) days of receiving a valid claim, Delta Dental will make available an Explanation of Benefits which records Delta Dental's Benefit determination, any payment made on behalf of the Plan by Delta Dental, and any amount still owed to the dental Provider. The Explanation of Benefits will be made available to the Plan Participant, or other appropriate beneficiary, and to the treating Provider if a Delta

Dental Participating Provider. The thirty (30) day period for claim determination may be extended by an additional fifteen (15) days if matters beyond the control of Delta Dental delay Benefit determination. Notification of any necessary extension will be sent prior to the expiration of the initial thirty (30) day period.

7. If a claim for Benefits is reduced or denied, the Explanation of Benefits will state the reason for the Adverse Benefit Determination. Should a Plan Participant believe Delta Dental incorrectly denied all or part of a claim, a review may be requested by following the steps described in, "Claims Appeal."
8. You may appoint an Authorized Representative to make contact with Delta Dental on your behalf with respect to any Benefit claim you file or any review of a denied claim you wish to pursue. To download a form to designate your Representative, visit www.deltadentalnm.com, or request a form by calling the Customer Service Department at (505) 855-7111 or toll-free (877) 395-9420, or mailing a letter to 2500 Louisiana Boulevard N.E. Suite 600, Albuquerque, New Mexico, 87110. Once you have appointed an Authorized Representative, Delta Dental will communicate directly with your Representative.
9. For questions and assistance regarding your coverage, you may contact the Plan Sponsor or call Delta Dental's Customer Service Department at (505) 855-7111 or toll-free (877) 395-9420. You may also write to Delta Dental's Customer Service Department at 2500 Louisiana Boulevard N.E. Suite 600, Albuquerque, New Mexico, 87110. When writing to Delta Dental, please include your name, the Group's name, your member ID number, and your daytime telephone number.
10. Pre-Treatment Estimates – A Pre-Treatment Estimate of Benefits provides both the patient and the Provider with an estimate of the Benefit levels, maximums, and limitations that may apply to a proposed treatment plan. Most importantly, the Plan Participant's share of the cost will be estimated, allowing you to know what services may be covered before your Provider provides them. A Pre-Treatment Estimate is not required to receive payment, unless specified in the Summary of Dental Plan Benefits. Your Provider submits the proposed dental treatment to Delta Dental in advance of providing the treatment. You and your Provider should review your Pre-Treatment Estimate before treatment. Once treatment is complete, the dental office will submit a claim to Delta Dental for payment on behalf of the Plan.
 - a. A Pre-Treatment Estimate is for informational purposes only and is not required before you receive dental care, unless specified in the Summary of Dental Plan Benefits. It is not a prerequisite or condition for approval of future dental Benefits payment. You will receive the same Benefits under this Plan whether or not a Pre-Treatment Estimate is requested. The Benefits estimate provided on a Pre-Treatment Estimate notice is based on Benefits available on the date the notice is received. It is not a guarantee of future dental Benefits or payment.
 - b. Availability of dental Benefits at the time your treatment is completed depends on several factors. These factors include, but are not limited to, your continued eligibility for Benefits, your available annual or lifetime Maximum Benefit Amount, Coordination of Benefits, the status of your Provider, this Plan's limitations and any other provisions, together with any additional information or changes to your dental treatment. A request for a Pre-Treatment Estimate is not a claim for Benefits or a preauthorization, precertification, or other reservation of future Benefits.
11. If a Plan Participant receives emergency care for services specified in your dental Plan and cannot reasonably reach a Participating Provider (as outlined in the Summary of Dental Plan Benefits), the emergency care rendered during the course of the

emergency will be reimbursed as though the Enrollee had been treated by a Participating Provider.

C. Out-of-Pocket Expenses

To help keep the premium levels affordable, the Plan is designed for cost sharing between the Plan Participant and the Plan Sponsor for the services provided by a dental provider.

1. Deductible

This Plan may require Plan Participants to pay a portion of the initial expense toward some Covered Services in each Benefit Period. When applicable, the amount of this Deductible is stated in the Summary of Dental Plan Benefits.

2. Patient Coinsurance

The patient coinsurance is the percentage of Covered Services that the Plan Participant is responsible for paying to the dental provider. The amount of patient coinsurance will vary depending on the level of benefits for the particular dental treatment and the selection of a Participating or a Non-Participating Provider as described in the accompanying Summary of Dental Plan Benefits.

3. Maximum Benefit Amount

The Plan will pay for Covered Services up to a maximum amount for each Plan Participant for each Benefit Period. Plan Participants are responsible for payment of amounts due for any dental services that exceed the Maximum Benefit Amount applicable in the Benefit Period. The Maximum Benefit Amount is stated in the Summary of Dental Plan Benefits.

D. Clinical Review

1. All claims are subject to review by a Dental Consultant. A Dental Consultant is a licensed New Mexico Dentist who has no affiliation or connection with Delta Dental other than as an independent consultant.
2. Payment of Benefits may require that a Plan Participant be examined by a licensed Dental Consultant or an Independent Licensed Dentist.
3. Delta Dental may require additional information prior to approving a claim. All information and records acquired by Delta Dental will be kept confidential.

E. To Whom Benefits Are Paid

1. On behalf of the Plan, Delta Dental will pay a Practicing Provider directly for Covered Services rendered. The Plan Participant is responsible for paying the Provider directly for any Coinsurance, Deductible, and non-covered services.
2. On behalf of the Plan, Delta Dental will pay a New Mexico Non-Participating Provider when an assignment of Benefits is received on the individual claim.
3. On behalf of the Plan, Delta Dental will pay a Non-Participating Provider practicing outside the state of New Mexico when required by law or when required by the Delta Dental Plan in that state, and when an assignment of Benefits is received on the individual claim.
4. All available Benefits not paid to the dental Provider shall be payable to the Primary Plan Participant or to the estate of the Primary Plan Participant.
5. On behalf of the Plan, Delta Dental must pay directly to the Human Services Department or Indian Health Services any eligible dental Benefits under this Contract which have already been paid or are being paid by the Human Services Department or

Indian Health Services on behalf of the Plan Participant under the state's Medicaid Program or Indian Health Program.

6. In cases of a Qualified Medical Child Support Order (QMCSO), on behalf of the Plan, Delta Dental will send Benefit payments directly to Participating Providers. Payment of Benefits for services obtained from Non-Participating Providers will be directed in compliance with the valid order of judgment provided in the QMCSO.

F. Right to Recover Benefits Paid by Mistake

If, on behalf of the Plan, Delta Dental makes a benefit payment to the Primary Plan Participant or to a provider and the patient is subsequently determined as not eligible for all or part of that Benefit, Delta Dental has the right to recover payment. If Benefit payment is made under fraudulent, false, or misleading pretenses or circumstances, Delta Dental has the right to recover that payment, on behalf of the Plan. The right to recover a payment includes the right to deduct the amount paid from future dental Benefits for any covered family member. An explanation of the payment being recovered will be provided at the time a deduction is made.

IV. Benefits, Limitations, and Exclusions

Your Benefits are outlined in your Summary of Dental Plan Benefits. Unless specified otherwise in the Summary of Dental Plan Benefits, the following Benefits, limitations, and exclusions described in this section apply to this Plan. A dental service will be considered for Benefits based on the date the service is started. Benefits are subject to the Processing Policies of Delta Dental and the terms and conditions of the entire Contract. Refer to the accompanying Summary of Dental Plan Benefits for patient Coinsurance amounts. In addition to the limitations applicable to each type of service, refer to “General Limitations and Exclusions” for a detailed list of other applicable Plan exclusions. To the extent that anything set forth herein conflicts with your Summary of Dental Plan Benefits, your Summary of Dental Plan Benefits will control.

A. Diagnostic and Preventive Services

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

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

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

B. Limitations on Diagnostic and Preventive Services

1. Benefit for patient prediagnostic screenings is limited to once in a calendar year. A separate fee for patient assessment is Disallowed.
2. A caries risk assessment and documentation, with a finding of low, moderate, or high risk, is a Benefit once every thirty-six (36) months.
 - a. A separate fee for a caries risk assessment is Disallowed when submitted for children under the age of three (3).
 - b. A separate fee for a caries risk assessment is Disallowed within twelve (12) months of the date of service.
 - c. A caries risk assessment is not a Benefit at twelve (12) to thirty-six (36) months from the date of service.
 - d. A separate fee for a caries risk assessment is Disallowed when the procedure is performed in addition to any other risk assessment procedure on the same date of service by the same Provider or dental office.
3. Blood glucose level tests and HbA1c tests are not Covered Services.
4. Brush biopsies are limited to once in a twelve (12) month period. A separate fee for interpretation is Disallowed.
5. Benefits for oral examinations, including diagnostic consultations, emergency or re-evaluation exams, clinical oral evaluations, routine cleanings, periodontal maintenance, and topical fluoride treatment are limited as shown in the Summary of Dental Plan Benefits.
6. Enrollees under the age of fourteen (14) are limited to routine child cleanings. Enrollees age fourteen (14) and over will be considered adults for the purpose of determining Benefits for cleanings.

7. A separate fee for periodontal maintenance may be disallowed within three (3) months of other periodontal therapy provided by the same dentist or dental office, as determined by clinical review.
8. Full mouth debridement is only a benefit when necessary to enable comprehensive evaluation and diagnosis and is limited to once per lifetime.
9. The Plan will Benefit a complete series of radiographic images as stated in the Summary of Dental Plan Benefits. A panoramic radiographic image with or without bitewing images is considered a complete series of radiographic images. Images exceeding the diagnostic equivalent of a complete series of radiographic images will be Disallowed when taken on the same date of service. Bitewing radiographic images exceeding the diagnostic equivalent of a complete series of radiographic images will be Disallowed when taken on the same date of service.
10. Emergency palliative treatment does not include Services and Supplies that exceed the minor treatment of pain. Benefit is limited to radiographic images and tests necessary to diagnose the emergency condition.
11. Services for diagnostic casts, oral/facial photographic images, laboratory and diagnostic tests, non-routine diagnostic imaging, non-surgical collection of specimens, oral hygiene instruction, home fluoride, mounted case analysis, and nutrition or tobacco counseling are not covered. A separate fee for image interpretation is Disallowed.
12. Pulp tests are a Benefit per visit, not per tooth, and only for the diagnosis of emergency conditions. Fees for pulp tests are Disallowed as part of any other definitive procedure on the same day by the same Provider or dental office except for limited oral evaluation (problem focused), palliative treatment, radiographic images, and protective restorations.
13. Benefits for sealants are limited to permanent molars free from occlusal restorations and a Covered Service for Enrollees as stated in the Summary of Dental Plan Benefits.
14. A separate fee for the replacement or repair of a sealant by the same Provider or dental office is Disallowed within two (2) years of the initial placement.
15. An age limitation may apply to services related to space maintainers. Please refer to the Summary of Dental Plan Benefits for applicable age limitations.
16. Fixed bilateral space maintainers are payable once per arch per lifetime for people up to age fourteen (14).
17. Fixed unilateral, removable unilateral, and removable bilateral space maintainers are payable once per quadrant per lifetime for people up to age fourteen (14).
18. A separate fee for the removal of a space maintainer by the same Provider or dental office who placed the initial appliance is Disallowed. Removal of a space maintainer by a different Provider or dental office is a Benefit once per appliance per lifetime.
19. Benefits for distal shoe space maintainers are payable once per area per lifetime for people up to age nine (9).
20. A separate fee for the repair or adjustment of a distal shoe space maintainer by the same Provider or dental office who placed the initial appliance is Disallowed.
21. A separate fee for the recementation, re-bond, or repair to a space maintainer by the same Provider or dental office is Disallowed within six (6) months of the original

treatment. Six (6) months after the original treatment date, recementation, re-bond, or repair is a Benefit once per twelve (12) month period.

22. Interim carriers arresting medicament application is limited to twice per tooth per Benefit Period.
23. Preventive restorations are not a Benefit.
24. Refer to “General Limitations and Exclusions” for additional provisions that may apply.

C. Restorative Services

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

D. Limitations on Restorative Services

1. A separate fee for the replacement of a restoration or any component of a restoration on a tooth for the same surface by the same Provider or dental office is Disallowed if done within twenty-four (24) months of the initial service.
2. When multiple restorations involving multiple surfaces of the same tooth are performed, Benefits will be limited to that of a multi-surface restoration. A separate Benefit may be allowed for a non-contiguous restoration on the buccal or lingual surface(s) of the same tooth subject to clinical review.
3. Unless listed in the Summary of Dental Plan Benefits, resin restorations in posterior teeth are limited to premolars and maxillary first molars. On all other teeth, they are considered optional services and are limited to the equivalent amalgam restoration Benefit.
4. Prefabricated resin crowns are a Benefit for primary anterior teeth only.
5. Services for metallic, porcelain/ceramic, or composite/resin inlays are limited to the Benefit for the equivalent amalgam/resin filling procedure.
6. Services for metallic, porcelain/ceramic, or composite/resin onlays are subject to clinical review, and limitations on optional services may apply.
7. Replacement of existing restorations (fillings) for any purpose other than treating active tooth decay or fracture is not covered.
8. Separate fees for more than one (1) pin per tooth or a pin performed on the same date of service as a build-up are Disallowed. A separate fee for the replacement of pin retention on the same tooth, by the same Provider or dental office, within twenty-four (24) months is Disallowed.
9. Refer to “General Limitations and Exclusions” for additional provisions that may apply.

E. Basic Services

Anesthesia: Intravenous sedation and general anesthesia.

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

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

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

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

F. Limitations on Basic Services

1. Evaluation for deep sedation or general anesthesia is Disallowed when billed in conjunction with an evaluation by the same Provider or dental office.
2. Intravenous (IV) sedation and general anesthesia are not Benefits for non-surgical extractions and/or patient apprehension.
3. Intravenous (IV) sedation and general anesthesia are Benefits only when administered by a licensed Provider in conjunction with specified surgical procedures, subject to clinical review and when Medically Necessary.
4. Nitrous oxide and non-intravenous conscious sedation are not covered Benefits.
5. Benefits for pulpal therapy procedures are limited to once in a twenty-four (24) month period.
6. A separate fee is Disallowed for pulp therapy procedures when performed on the same day, by the same Provider or dental office, as other surgical procedures involving the root.
7. A separate fee is Disallowed for a pulp cap placed on the same day as a restoration or within twenty-four (24) months of a pulp cap placed on the same tooth by the same Provider or dental office.
8. A pulpotomy or pulpal debridement is a Benefit once per tooth per lifetime.
9. Benefits for certain oral surgery procedures are subject to the receipt of an operative report and clinical review, and may be reduced by benefits provided under the patient's medical benefits coverage, if applicable.
10. Root canal therapy in conjunction with overdentures is not a Benefit.
11. Re-treatment of root canal therapy or re-treatment of surgical procedures involving the root, by the same Provider or dental office, within twenty-four (24) months, is considered part of the original procedure and a separate fee is Disallowed.
12. Apexification Benefits are limited to permanent teeth, once per tooth per lifetime. This procedure is Disallowed if performed by the same Provider or dental office within twenty-four (24) months of root canal therapy.
13. Endodontic endosseous implants are not a Benefit.
14. Tooth transplantation, including re-implantation, is not a Benefit.
15. Scaling in the presence of generalized moderate or severe gingival inflammation is considered to be a cleaning for Benefit frequency determination.
16. Periodontal scaling and root planing are a Benefit once per quadrant or site in a two (2) year period.

17. Localized delivery of antimicrobial agents may be performed at six (6) weeks to six (6) months after initial therapy (scaling and root planing or surgery) on no more than two (2) sites per quadrant, with pocket depth at least five (5) millimeters and less than ten (10) millimeters.
 - a. If different teeth are treated in the quadrant within twelve (12) months, the treatment is not a Benefit.
 - b. If the same teeth are re-treated within twenty-four (24) months, the treatment is not a Benefit.
18. Periodontal surgeries, such as gingivectomy, gingival flap, osseous surgery, bone grafts, and tissue graft procedures are limited to once per site in a three (3) year period.
19. Gingivectomy or gingivoplasty to allow access for a restorative procedure is considered part of the restorative procedure.
20. A bone replacement graft, biologic materials, or guided tissue regeneration in conjunction with an apicoectomy, gingivectomy, crown lengthening, retrograde filling, root amputation, periradicular surgery, soft tissue grafts, subepithelial tissue grafts, extraction, implant site, ridge augmentation, anatomical crown exposure, wedge procedure, or an apically positioned flap is a Specialized Procedure and not a Benefit.
21. Extra-oral soft tissue grafts (grafting of tissues from outside the mouth to oral tissues) or bone graft accession from a donor site is not a Benefit.
22. Separate fees for crown lengthening in the same site are Disallowed when charged by the same Provider or dental office within three (3) years.
23. Additional fees for more than two (2) quadrants of osseous surgery on the same day of service are Disallowed.
24. Separate fees for postoperative visits and/or dressing changes by the same Provider or dental office performing the treatment are Disallowed.
25. Refer to “General Limitations and Exclusions” for additional provisions that may apply.

G. Major Services

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

Crowns and Cast Restorations, Including Repairs to Covered Procedures: Benefits when a tooth is damaged by decay or fractured to the point that it cannot be restored by an amalgam or resin filling.

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

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

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

H. Limitations on Major Services

1. Replacement of cast restorations (including veneers, crowns, pontics, inlays, and onlays) and associated procedures (such as cores and substructures) on the same tooth are not a Benefit if the previous placement is less than five (5) years old.
2. Inlays are not a Covered Service and will be optioned to an amalgam or resin restoration.
3. Veneers are not a Covered Service and will be optioned to a resin restoration.
4. Replacement of a bridge or denture is not a Benefit if the previous placement is less than five (5) years old.
5. Services which are beyond the standard of care customarily provided, or not necessary to restore function, are limited to the Benefit applicable to a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
6. Cantilever bridges are beyond the standard of care customarily provided and are subject to clinical review.
7. Overdentures are not a Covered Service.
8. Substructures are only a Benefit when necessary to retain a cast restoration due to the extensive loss of tooth structure from caries or fracture. Substructures are Disallowed when enough tooth structure is present to retain a cast restoration.
9. The fee for a core build-up and/or substructures is Disallowed when performed in conjunction with inlays, onlays, $\frac{3}{4}$ crowns, and veneers.
10. Posts and cores in addition to a crown are a Benefit only on endodontically treated teeth. In addition to the requirement for endodontic treatment, anterior teeth must have insufficient tooth structure to support a cast restoration. Fees are Disallowed when these requirements are not satisfied.
11. A separate fee for the recementation or re-bond to crowns, implants, inlays, onlays, posts and cores, veneers, or bridges within six (6) months of the original treatment by the same Provider or dental office is Disallowed.
12. A separate fee for the repair to crowns, inlays, onlays, or veneers within twenty-four (24) months of the original treatment by the same Provider or dental office is Disallowed.
13. A separate fee for the repair to crowns, inlays, onlays, or veneers within twenty-four (24) months of the original treatment by a different Provider or dental office is not a benefit.
14. Services for the recementation, re-bond, or repair to crowns, implants, inlays, onlays, posts and cores, veneers, or bridges are a Benefit once per twelve (12) months. Procedures to modify existing partials and dentures are considered construction of prosthesis, not the repair of prosthesis.
15. A pontic required due to spaces in excess of those resulting from the extraction of the normal complement of natural teeth is a special condition of that patient's mouth and is not a Benefit.
16. Surgical placement of an implant body is a Benefit once per tooth per five (5) year period.

17. Implant supported prosthetics and/or abutment supported crowns are not a Benefit if the previous placement is less than five (5) years old. This limitation applies to the placement of crowns on natural teeth, abutment supported crowns on implants, and fixed partial denture pontics.
18. Implant maintenance procedures are limited to twice in a Benefit Period.
19. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure are subject to these limitations and/or exclusions:
 - a. A separate fee is Disallowed when the procedure is performed in conjunction with routine cleanings, periodontal maintenance, root planing and scaling, gingival flap procedures, periodontal osseous surgery, or debridement of a peri-implant defect.
 - b. This Benefit is limited to once per tooth per twenty-four (24) months.
 - c. A separate fee for this procedure by the same Provider or dental office within twenty-four (24) months of initial therapy is Disallowed.
 - d. A separate fee is Disallowed when this procedure is performed within twelve (12) months of implant-supported crown or bridge procedures by the same Provider or dental office.
20. Stress breaker, semi-precision, or precision attachments or the replacement of an implant/abutment supported prosthesis is considered an optional service and is not a Benefit.
21. A separate fee for the removal of an implant within twenty-four (24) months of the original placement, by the same Provider or dental office, is Disallowed. After twenty-four (24) months, this service is a Benefit once per tooth per lifetime.
22. A separate fee is Disallowed for a radiologic surgical implant index.
23. A posterior fixed bridge and a partial denture are not Benefits in the same arch. Benefit is limited to the allowance for a partial denture.
24. Temporary restorations, temporary implants, and temporary prosthodontics are considered part of the final restoration. A separate fee by the same Provider or dental office is Disallowed.
25. Benefits for porcelain crowns or porcelain supported prosthetics on posterior teeth are limited to premolars and maxillary first molars. On all other teeth, they are considered optional services and Benefits are limited to the equivalent metal crown or metal supported prosthetic Benefit.
26. Maxillofacial prosthetics and related services are not a Benefit.
27. Crowns, implants, prosthodontics, and all related services are not Benefits for Enrollees under the age of sixteen (16).
28. Fees for full or partial dentures include any relines/rebase, adjustment, or repair required within six (6) months of delivery except in the case of immediate dentures. After six (6) months, adjustments to dentures are a Benefit twice in a twelve (12) month period and relines or rebases are a Benefit once in a three (3) year period.
29. Tissue conditioning is not a Benefit more than twice per denture unit in a three (3) year period.

30. Treatment of Temporomandibular/Craniomandibular Disorders (TMD) is covered within the scope of dental practice and does not include coverage for orthodontic appliances and treatment, crowns, bridges, and dentures unless the disorder is trauma related.
31. Refer to “General Limitations and Exclusions” for additional provisions that may apply.

I. Orthodontic Services

Coverage for this category of services only applies under the High Option Plan (not covered under the Low Option Plan).

No payment will be made by the Plan for Orthodontic Services, or any services related to an orthodontic treatment plan unless stated in the Summary of Dental Plan Benefits.

Orthodontic Services are procedures performed by a Provider using appliances to treat poor alignment of teeth and their surrounding structure. The Benefit determination for the Orthodontic Lifetime Maximum may include specific non-orthodontic procedure codes that are directly related, as determined by Delta Dental, to be part of an orthodontic treatment plan. Procedures directly related to Orthodontic Services will only be considered eligible expenses if Benefits for Orthodontic Services apply.

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

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

J. Limitations on Orthodontic Services

1. If the Plan Participant is already in orthodontic treatment, Benefits shall commence with the first treatment rendered following the patient’s Effective Date or any applicable Benefit waiting period. Charges for treatment incurred prior to the patient’s Effective Date are not covered.
2. Benefits are determined based on the total cost and total months of treatment.
3. Benefits will end immediately if orthodontic treatment is stopped.
4. Charges to repair or replace any orthodontic appliance (including, but not limited to, retainers and replacement retainers) are not covered, even when the appliance was a covered Benefit under this or any other Plan.
5. Charges for radiographic images (except for cephalometric radiographic images) and extractions are not covered under Orthodontic Services.
6. Oral/facial photographic images and diagnostic casts are a Benefit once per orthodontic treatment case. Additional fees for these procedures are Disallowed when performed by the same Provider or dental office.
7. Self-directed or “at-home” orthodontic treatment is not a Benefit.
8. Refer to “General Limitations and Exclusions” for additional provisions that may apply.

K. General Limitations and Exclusions

1. A Benefit waiting period prior to obtaining some services applies if stated in the Summary of Dental Plan Benefits. This means a Plan Participant is not eligible for

Benefits for those services until he/she has been continually enrolled under this Contract for the time frame stated in the Summary of Dental Plan Benefits.

2. Services for any covered procedures which exceed the frequency or age limitation shown in the Summary of Dental Plan Benefits are not eligible for Benefits. Unless stated otherwise, all frequency limitations are measured from the last date a procedure was performed according to the patient's dental records.
3. Services beyond treatment that is considered the standard of care customarily provided are considered "optional or specialized services." These services may include the use of alternative techniques, special materials, and services of a cosmetic intent.
 - a. If a Plan Participant receives optional or specialized services, Benefits may be provided based on the customary or standard procedure. A determination of optional or specialized services is not an opinion or judgment on the quality or durability of the service. The Plan Participant will be responsible for any difference between the cost of optional or specialized services and any Benefit payable.
4. Charges for cone beam CT capture and interpretation services are not a Benefit.
5. Treatment of injuries or illness covered by Workers' Compensation or employers' liabilities laws or services received without cost from any federal, state, or local agencies are not a Benefit.
6. Treatment to restore tooth structure lost from wear is not covered.
7. Cosmetic surgery or procedures are not covered.
8. Prosthodontic services or any single procedure started before the patient is covered under this Plan is not eligible for Benefits.
9. Prescribed drugs, pain medications, desensitizing medications, therapeutic drug injections, and non-invasive physical therapies are not covered unless part of a Medically Necessary TMD treatment plan and subject to approval by Delta Dental.
10. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dental or medical Provider for treatment in any such facility are not Covered Services.
11. A separate fee for a consultation with a medical care professional is Disallowed.
12. A separate fee for certified translation or sign language services is Disallowed.
13. Dental case management services are subject to these limitations and/or exclusions:
 - a. A separate fee for addressing appointment compliance barriers is Disallowed.
 - b. A separate fee for care coordination is Disallowed.
 - c. Motivational interviewing is not a Benefit.
 - i. If this service is performed on the same date of service as nutritional counseling for control of dental disease, tobacco counseling for the control and prevention of oral disease, or oral hygiene instructions, a separate fee for this service is Disallowed.
 - d. Patient education to improve oral health literacy is not a Benefit.
 - i. If this service is performed on the same date of service as nutritional counseling for control of dental disease, tobacco counseling for the control

and prevention of oral disease, or oral hygiene instructions, a separate fee for this service is Disallowed.

14. Orthodontic Services, or any services related to an orthodontic treatment plan, are not covered unless stated in the Summary of Dental Plan Benefits.
15. Treatment must be provided by a licensed Dentist or a person who by law may work under a licensed Dentist's direct supervision.
16. A separate charge for office visits, non-diagnostic consultations, case presentations, or cancelled or missed appointments is not covered.
17. Administrative services, including to duplicate/copy patient records, are not Covered Services.
18. Treatment to correct harmful habits is not covered.
19. A separate charge is Disallowed for behavior management, infection control, sterilization, supplies, and materials.
20. Charges for Services or Supplies that are not necessary according to accepted standards of dental practice are not Benefits.
21. Charges for Services, Supplies, or devices which are not a Dental Necessity are not Benefits.
22. Services or Supplies, as determined by Delta Dental, that are Experimental or Investigational in nature are not covered. This includes Services and Supplies required to treat complications from Experimental or Investigational procedures.
23. A hemisectioned tooth will not be Benefited as two (2) separate teeth.
24. Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion is not a Benefit.
25. Treatment to stabilize teeth is not a Benefit.
26. Occlusal or athletic mouth guards and related services are not a Benefit unless part of a Medically Necessary TMD treatment plan and subject to approval by Delta Dental.
27. Replacement of existing restorations (fillings) for any purpose other than treating active tooth decay or fracture is not covered. A tooth fracture or crack is defined as tooth structure that is mobile and/or separated from the natural tooth structure.
28. Charges for treatment of craze lines are not a Benefit. A "craze line" is a visible micro-fracture located in coronal enamel that does not break or split the continuity of the tooth structure.
29. Sales tax is not a Benefit.
30. Separate fees are Disallowed for procedures which are routinely considered by Delta Dental to be part of another service, if performed by the same Provider or dental office on the same date of service.
31. Services or Supplies excluded by the policies and procedures of Delta Dental, including the Processing Policies, are not a Benefit.
32. Services or Supplies for which no charge is made, for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage are not covered by the Plan.

33. Services or Supplies received due to an act of war or terrorism, declared or undeclared, are not a Covered Service.
34. Services for patients with specified medical conditions, or any services related to the specified medical conditions treatment plan, are not covered.
35. Services or Supplies that are not within the categories of Benefits selected by the Plan Sponsor and that are not covered under the terms of this Handbook are not a Benefit.

V. Coordination of Benefits

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

A Plan Participant will provide Delta Dental with the necessary information needed to administer COB. Delta Dental may release required information or obtain required information in order to coordinate the Benefits of a Plan Participant.

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

A. Determining Which Plan is Primary

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

1. Medicaid or Indian Health Services – Delta Dental is always the primary plan to any benefits payable by Medicaid or Indian Health Services.
2. Non-Coordinating Plans – If you have another plan that does not coordinate benefits, it will always be the primary plan.
3. Hospital, Surgical/Medical, or Prescription Drug Plans – These are the primary plan if the plan provides benefits for dental related services including but not limited to: treatment due to accidental injuries, surgical extraction of impacted wisdom teeth, oral surgery, the administration of general anesthesia, and Temporomandibular Joint Disorder.
4. Employee or Subscriber – The plan that covers the Plan Participant other than as an Enrolled Dependent is primary. For example, the plan that covers you as the employee or Subscriber, neither laid off nor retired, is the primary plan.
5. Children and the Birthday Rule – The plan of the parent whose birthday is earliest in the calendar year is always primary for children. For example, if your birthday is in January and your Spouse's birthday is in March, your plan will be primary for all of your children. If both parents have the same birthday, the plan that has covered the parent for the longer period will be primary.
6. Children with Parents Divorced or Separated
 - a. If a court decree makes one parent responsible for health care expenses, that parent's plan is primary.

- b. If a court decree states that the parents have joint custody without stating that one of the parents is responsible for the child's health care expenses, Delta Dental follows the birthday rule (see rule 5 above). If neither of these rules applies, the order will be determined as follows:
 - i. First, the plan of the parent with custody of the child;
 - ii. Then, the plan of the Spouse of the parent with custody of the child;
 - iii. Next, the plan of the parent without custody of the child; and
 - iv. Last, the plan of the Spouse of the parent without custody of the child.
7. Laid-Off or Retired Enrollees – The plan that covers the Plan Participant as a laid-off or retired employee or as a dependent of a laid-off or retired employee.
8. COBRA Coverage – The plan that is provided under a right of continuation pursuant to federal or a similar state law (that is COBRA).
9. Other Plans – If none of the rules above determines the order of benefits, the plan that has covered the Enrollee for the longer period will be primary.

B. How Delta Dental Pays as Primary

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

C. How Delta Dental Pays as Secondary

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

D. Right of Recovery

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

1. The people it has paid or for whom it has paid;
 - a. Insurance companies; or
 - b. Other organizations.

VI. Claims Appeal

A. Voluntary Appeal Procedure

1. A Plan Participant may request a review of a claim by following Delta Dental's claim appeal procedures. All of Delta Dental's claim appeal procedures are voluntary and are designed to provide a full and fair review of any Adverse Benefit Determination. An Adverse Benefit Determination means a denial, reduction, or termination of a Benefit or a failure to make payment, in whole or in part, on a claim.
2. The decision as to whether to request a review or to appeal a claim will have no effect on the patient's right to any other Benefits under the Plan. In addition, the following provisions are assured. The Plan Participant:

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

B. Informal Claim Review Process

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

C. Formal Claim Appeal Process

If a Plan Participant disagrees with a Benefit determination, a formal review of the claim may be requested by filing an appeal with Delta Dental within one hundred eighty (180) days following receipt of Delta Dental's notification of an Adverse Benefit Determination. An appeal is a formal, written request to change a previous decision made by Delta Dental. There are two (2) types of appeals: Appeal of Claim Processing Procedure and Appeal of Claim for Dental Treatment.

1. Appeal of Claim Processing Procedure means the Plan Participant is requesting a review of the application by Delta Dental of an administrative, procedural, or Plan Benefit provision which resulted in an Adverse Benefit Determination.
 - a. An Adverse Benefit Determination may be appealed by sending a request in writing to Delta Dental describing the reasons for requesting a review and including any additional information that the Plan Participant wishes to be considered.
 - b. A Delta Dental representative, who is neither the individual who made the initial claim determination nor the subordinate of such individual, will conduct a review of the claim. The results of the review will be provided in writing to both the Plan Participant and to the treating dental Provider, as appropriate.

2. Appeal of Claim for Dental Treatment is a request for a review of an Adverse Benefit Determination that resulted from a clinical review conducted by a Delta Dental Dental Consultant. Three (3) voluntary options for appeal are available:
 - a. The Plan Participant may appeal an Adverse Benefit Determination by sending a request in writing to Delta Dental describing the reasons for the appeal and including any additional information the Plan Participant wishes to be considered. A Dental Consultant, who is neither the individual who made the initial claim determination nor the subordinate of that individual, will provide a full and fair subsequent and independent review of the claim.
 - i. If the second consulting Dentist determines the treatment was Dentally Necessary, Delta Dental will recalculate the claim for available Benefits and send written notification of payment to the Plan Participant and the treating Provider. In the event the second consulting Dentist also determines the treatment was not Dentally Necessary according to the terms of the Plan provisions or standard dental treatment, the Adverse Benefit Determination will be upheld. Delta Dental will send notification to the Plan Participant and to the treating dental Provider, as appropriate.
 - b. The Plan Participant may appeal an Adverse Benefit Determination and request an independent oral examination by writing to Delta Dental, describing the reasons for the request, and including additional information the Plan Participant wishes to be considered. A Dental Consultant, who has neither been involved in previous determinations of the claim under review nor is a subordinate of that individual, will provide a full and fair independent review of the claim.
 - i. If the second consulting Dentist agrees the treatment was Dentally Necessary, Delta Dental will recalculate the claim for available Benefits and send written notification of payment to the Plan Participant and the treating dental Provider, as appropriate.
 - ii. In the event the second consulting Dentist determines the treatment was not Dentally Necessary according to the terms of this Plan or standard dental treatment, an oral examination will be scheduled with a mutually agreed upon licensed Dentist. The fee for this oral examination will be the responsibility of Delta Dental and will not apply to the frequency limitations on exams under this Plan's Benefit provisions. If that examining Dentist agrees the treatment was Dentally Necessary, Delta Dental will recalculate the claim for available Benefits and send written notification of payment to the Plan Participant and the treating Provider. In the event the examining Dentist determines the treatment was not Dentally Necessary according to the terms of this Plan or standard dental treatment, the Adverse Benefit Determination will be upheld. Delta Dental will send written notification to the Plan Participant and to the treating Provider, as appropriate.
 - c. The Plan Participant may appeal an Adverse Benefit Determination and request an external peer review by the local or state dental society. Delta Dental will provide the Plan Participant with information on how to initiate the peer review process through the New Mexico Dental Association.

D. Grievance

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

New Mexico Board of Dental Health Care

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

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

VII. Termination of Coverage

A. When Coverage for a Plan Participant Ends

1. Unless stated otherwise in the Summary of Dental Plan Benefits, coverage ends on the last day of the month in which a Primary Plan Participant who loses coverage due to:
 - a. loss of eligibility;
 - b. voluntary cancellation of coverage;
 - c. cancellation of this Plan by your Group or Delta Dental;
 - d. entering an unapproved leave of absence. Upon return to work, coverage may resume as specified by the Plan Sponsor. An employee absent from work due to an approved leave of absence, including those governed by the "Family Medical Leave Act of 1993," may continue coverage without interruption during a leave period if the Plan Sponsor continues to report the Primary Plan Participant as an Enrollee and Premium is paid on the Enrollee's behalf.
2. An Enrolled Dependent loses coverage along with the enrolled Primary Plan Participant, or on the last day of the month in which dependent status is lost, whichever is earlier. Coverage for dependent children who reach age twenty-six (26) will automatically be terminated by Delta Dental the last day of the month in which the dependent child turns age twenty-six (26) unless Delta Dental receives proof of the dependent child's qualification for extended eligibility. Refer to the Summary of Dental Plan Benefits for any exceptions to the age twenty-six (26) limitation.
3. A Plan Participant and/or dependent may be eligible to continue coverage depending on the size of the Group and if certain conditions are met. Please refer to, "Continuation of Coverage," in this Handbook.

B. When Payment for Claims Ends

If a Plan Participant loses coverage, Delta Dental will only pay claims, on behalf of the Plan, for Covered Services incurred prior to the loss of coverage. To be considered for payment, claims must be submitted to Delta Dental in writing within twelve (12) months after the services have been provided and for which Benefits are payable and while the Plan Sponsor's Administrative Services Contract is still in effect.

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

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

Delta Dental dentist network on the date concurrent with the termination of the Administrative Services Contract.

VIII. Continuation of Coverage

A Plan Sponsor may be subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This means that Plan Participants may be entitled to continue coverage at their own expense under this dental Plan following certain Qualifying Events if certain conditions are met. To be eligible for continued coverage, the Plan Participant must be enrolled in this Plan on the day before the Qualifying Event occurs. The Plan Sponsor is responsible for providing Plan Participants with notification of COBRA continuation rights and for any/all administration related to those COBRA rights.

IX. Subrogation and Right of Reimbursement

To the extent that this Plan provides or pays benefits for covered services, the Plan Sponsor may be subrogated to any right you or your eligible dependent has to recover from another, his or her insurer, or under his or her "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions.

In the event the Plan Sponsor elects to pursue a subrogation matter, Delta Dental shall provide reasonable assistance to the Plan Sponsor. Such assistance shall be limited to providing the Plan Sponsor with documents, records, and demand letters.

X. Definitions

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

Administrative Services Agreement or Contract: The Plan Sponsor Administrative Services Contract document, including Article I “Declarations,” Dental Benefit Handbook, Summary of Dental Plan Benefits, and, if applicable, successor agreements or renewals initially or thereafter issued or executed.

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

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

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

Benefits: The amount Delta Dental will pay for covered dental services described in, “Benefits, Limitations, and Exclusions,” and in the Summary of Dental Plan Benefits.

Coinsurance: The percentage of the dental Provider’s approved fee due from the Plan Participant to the dental Provider.

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

Deductible: The amount a Plan Participant or family must pay toward Covered Services before Delta Dental makes any payment for those Covered Services.

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

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

Dental Benefit Handbook: This document. Delta Dental will provide Benefits, on behalf of the Plan, as described in this Handbook. Any changes in this Handbook will be based on changes to the Administrative Services Agreement between Delta Dental the Plan Sponsor.

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

Dental Necessity (Dentally Necessary): A Service or Supply provided by a Dentist or other Provider that has been determined by Delta Dental as generally accepted dental practice for the Plan Participant’s diagnosis and treatment. Delta Dental may use Dental Consultants to determine generally accepted dental practice standards and if a service is a Dental Necessity. These Services or Supplies are in accordance with generally accepted local and national standards of dental practice, and not primarily for the convenience of the Plan Participant or Provider. The Services/Supplies are the most appropriate that can safely be provided. The fact that a Provider has performed or prescribed a Service or Supply does not mean it is a Dental Necessity.

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

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

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

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

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

1. A technology must have final approval from the appropriate regulatory government bodies;
2. The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcome;
3. The technology must improve the net health outcome;
4. The technology must be as beneficial as any established alternatives; and
5. The technology must be attainable outside the Investigational settings.

Group: The employer named in the Summary of Dental Plan Benefits.

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

Maximum Approved Fee: The Maximum Approved Fee is the lowest of: (a) the Submitted Amount; (b) the lowest fee regularly charged, offered, or received by an individual Provider for a dental Service or Supply, irrespective of the Provider's contractual agreement with another dental benefits organization; or (c) the maximum fee that the local Delta Dental Plan approves for a given procedure in a given region and/or specialty, based upon applicable Participating Provider schedules and internal procedures. Participating Providers agree not to charge Delta Dental patients more than the Maximum Approved Fee for a Covered Service. In all cases, Delta Dental will make the final determination regarding the Maximum Approved Fee for a Covered Service.

Maximum Benefit Amount: The maximum dollar amount Delta Dental will pay, on behalf of the Plan, in a Benefit or lifetime Period for Covered Services for each Plan Participant.

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

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

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

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

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

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

Plan Participant: An enrolled employee, enrolled dependent, COBRA-enrolled person, or other person who meets the conditions of coverage eligibility outlined in "Eligibility, Enrollment and Effective Dates," whose completed enrollment information has been received and approved by the Plan Sponsor and for whom applicable administrative fees are paid.

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

Primary Plan Participant: An eligible employee or other person who meets the conditions of individual coverage eligibility outlined in "Eligibility, Enrollment and Effective Dates," whose completed enrollment information has been received and approved for coverage.

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

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

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

Qualifying Event: A specific, qualified circumstance that alters the eligibility status of an employee or that person's dependents under this Plan. Qualifying events include but are not limited to: marriage, childbirth, divorce, and involuntary loss of other coverage. The changes a Primary Plan Participant or a dependent makes to coverage due to a qualifying event must be consistent with that particular event. Events may affect eligibility differently. Delta Dental must receive notification of any change of eligibility status within sixty (60) days of a qualifying event.

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

Sound Natural Teeth: Those teeth that are either primary (A through T or AS through TS) or permanent (1 through 32 and 51 through 82) dentition that have adequate hard and soft tissue support.

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

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

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

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

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

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

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