Delta Dental Plan of New Mexico, Inc.

Dental Benefit Handbook

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This Dental Benefit Handbook and the Summary of Benefits (collectively "Plan"), describe important provisions for your dental Plan that is administered by Delta Dental Plan of New Mexico, Inc. ("Delta Dental", "Delta Dental of New Mexico", or "DDNM").

Benefits under the Plan are provided by your Group for the exclusive Benefit of eligible persons and their qualified dependents. The Group established this Plan as a self-funded dental Plan to provide 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 enrolled by this Plan at the time of such change.

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

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

For answers to questions about Benefits, contact Delta Dental of New Mexico:

Delta Dental of New Mexico
Attn: Customer Service Department
One Sun Avenue NE, Suite 400
Albuquerque, NM 87109
toll-free (877) 395-9420 or (505) 855-7111
customerservice@deltadentalnm.com

Your dental health is an important part of your overall wellness! This Plan is designed to promote regular dental visits. Take advantage of your Benefits by calling a Delta Dental Provider today for an appointment.

Table of Contents

I. Eligibility and Enrollment

A. Determining Eligibility

Subject to the specific eligibility rules set in your Summary of Benefits, the following eligibility rules apply. To the extent that these requirements conflict with those stated in your Summary of Benefits, the rules in your Summary of Benefits control.

1. Individuals who meet one of the following qualifications and enroll in this Plan are eligible:

a. An *employee* who satisfies the eligibility definition(s) and Eligibility Waiting Period as specified by the Group.

b. A *dependent* of the Eligible Employee defined as:

i. *Spouse* as defined by New Mexico State Law;

ii. *Domestic Partner* as defined by the Group or as otherwise required by law, unless stated otherwise in the Summary of Benefits;

iii. *Children* from birth through the end of the month of their twenty-sixth (26th) birthday, unless stated otherwise in the Summary of Benefits;

iv. *Children* over the limiting age of 26 years old who meet the requirement of the preceding Subsection 1(b)(iii) above and are *Totally and Permanent Disabled* under the following requirements:

(1) Medically certified as Disabled, meaning any medically determined physical or mental condition that prevents a Child over the limiting age of 26 years old from engaging in self-employment, and dependent upon the Enrolled Employee for support and maintenance as defined by the Internal Revenue Code of the United States; and

(2) The Enrolled Employee provides proof of disability and chief dependence within 31 days of the Dependent child's attainment of the limiting age of 26 and thereafter, as required, but no more frequent than annually after the two-year period following the Dependent child's attainment of the limiting age of 26.

v. Refer to your Summary of Benefits to verify age limitations that may apply to specific dental treatment and to the "Eligibility Provisions" to verify the dependent child age limitation.

2. The definition of "*children*" for the purposes of coverage under the Plan is:

a. natural child(ren);

b. newly born child(ren);

c. stepchild(ren);

d. child(ren) of a non-custodial parent;

e. child(ren) for whom the Enrolled Employee is the legal guardian;

f. legally adopted child(ren), including children placed with an Enrolled Employee, Spouse, or Domestic Partner for adoption. Coverage shall apply without any pre-existing Benefit restrictions;

g. foster child(ren) living in the same household as an Eligible Employee, Spouse, or Domestic Partner as a result of placement by a state licensed placement agency; or

h. dependent child(ren) required by a Qualified Medical Child Support Order ("QMCSO") or a court or administrative order are also eligible for coverage without regard to Open Enrollment restrictions.

B. Enrollment Requirements

1. Employees and their Eligible Dependents must enroll to be covered under the Plan. Unless required by law, Eligible Dependents may enroll only if the Eligible Employee enrolls. Enrollments must be completed and received within 31 days of the eligibility date.
2. Newly Eligible Employees and dependents may enroll in accordance with their dates of eligibility.
3. An Enrolled Employee may elect to enroll Eligible Dependents under the following conditions:
   a. Eligible Dependents must be enrolled at the time the Eligible Employee becomes enrolled, or within 31 days from the date they become dependents, or within 31 days of loss of other dental coverage, or during an Open Enrollment period;
   b. An Enrolled Employee may not also enroll as a dependent under the same employer's Plan;
   c. A dependent may enroll as the Enrollee of only one Enrolled Employee;
   d. Newly born dependents become eligible on the date of birth and may be enrolled on the Group's Effective Date, within 31 days of birth, or at Open Enrollment.
4. This Plan will allow an annual Open Enrollment period for all Eligible Employees of the Group. *Open Enrollment* is a period of time specified by the Group to allow Eligible Employees and/or their Eligible Dependents to enroll in the Plan or to cancel coverage under the Plan for the renewed Agreement period. Open Enrollment changes are effective on the first day of the Group's renewed Agreement period.
5. While an Enrolled Person is covered by this Plan, that Enrolled Person agrees to provide Delta Dental of New Mexico with any information it needs to process claims and administer Benefits. This includes authorizing Delta Dental of New Mexico to have access to an Enrolled Person's dental records.
6. If an Eligible Employee does not elect coverage when first eligible, they may only enroll during the next Open Enrollment period. Proof of loss of other dental coverage must be provided to your Employer within 31 days.

C. Effective Dates of Coverage

1. Unless otherwise approved by the Group and indicated in the Summary of Benefits, coverage for an Enrolled Employee becomes effective on the first day of the month following that employee's date of eligibility.
2. Coverage for newly born child(ren) will become effective on the date of birth, if enrolled within 31 days, but not before the coverage date applicable to the Enrolled Employee.
3. Coverage for Enrolled Dependents, except as noted in Subsection 2 above, becomes effective on the same date as the Enrolled Employee or on the first of the month following the dependent's date of eligibility.
4. You must notify Delta Dental of New Mexico in a timely manner through your employer or organization of any event that changes the eligibility status of an Enrollee or Eligible Dependent. Events that can affect the eligibility status of an Enrollee or Eligible Dependent include, but are not limited to, marriage, birth, death, and divorce. With respect to Qualifying Events that require the enrollment of an individual into this Plan including, but not limited to, marriage, birth, or adoption, your Employer must receive notification of such Qualifying Event within 31 days of such Qualifying Event. Delta Dental of New Mexico may require proof of the Qualifying Event.

D. Re-Enrollment after Voluntary Cancellation of Coverage

1. An Enrolled Employee may cancel employee or dependent coverage during an annual Open Enrollment period. Re-enrollment is not available until the next annual Open Enrollment period or upon subsequent loss of coverage.
2. Re-enrollment in the Plan between Open Enrollment periods after voluntary cancellation of coverage is not allowed for any reason other than the loss of other dental coverage or another Qualifying Event. Re-enrollment and proof of loss of other dental coverage must be provided to your Employer within 31 Days.

II. Accessing Your Benefits

A. Accessing Benefits

In general, you should follow these steps in using the Plan:

1. Read, review, and reference this Dental Benefit Handbook and the Summary of Benefits to understand:
    - Your Benefits,
    - Your requirements and responsibilities under this Plan,
    - Delta Dental Provider Networks available under your Plan,
    - How to select a Delta Dental Provider; and
    - Other requirements of this Plan.
2. In making an appointment with a Dental Provider, let them know that you have coverage with Delta Dental of New Mexico under this Plan. If they are

unfamiliar with the Plan, have them contact our **Customer Services Team** at **(877) 395-9420** or at **(505) 855-7111** Monday-Friday from 8 a.m.-4:30 p.m. MST. Automated system is available 24/7.

3. When you or an Enrolled Dependent receive Services, a Claim must be filed with us.
4. If you have any question about how your Plan works, Benefits, selecting a Dental Provider or a Claim, contact our **Customer Services Team** toll free **(877) 395-9420** or **(505) 855-7111** Monday-Friday from 8 a.m.-4:30 p.m. MST. or by email at **customerservice@deltadentalnm.com**.

B. Selecting a Dental Provider

1. The Summary of Benefits contains specific information about your specific Delta Dental Provider Network(s).
2. You will have the lowest out-of-pocket costs when you select a Delta Dental Provider who participates in a Delta Dental Provider Network.
3. You can search for a Delta Dental Provider on **deltadentalnm.com**.
4. You are not required to pre-select a Dental Provider and Delta Dental of New Mexico does not guarantee that a particular Dental Provider will be available.
5. You and each Enrolled Dependent may choose a different Dental Provider.
6. You are responsible for the full payment for any non-Covered Services.

C. Advantages of Using a Delta Dental Provider

You will find a Delta Dental Provider near to where you live or work. Delta Dental Providers agree to offer quality Services to you and your Enrolled Dependents at contracted rates. This assures that you can access the most affordable and quality Services. It also helps you lower your out-of-pocket costs to you and protects you against *Balance Billing*.

By choosing a Delta Dental Provider, you can also obtain the full advantage of your coverage such as:

1. Access to quality Services from professionally credentialed Delta Dental Providers;
2. Access to affordable Services to assure the most efficient use of your Maximum Limits for your dental health and well-being;
3. Lower out-of-pocket costs to save you money;
4. Protect you against surprised *Balance Billing* from a Dental Provider;
5. Less time and paperwork for you, as Delta Dental Providers are required to submit claims and supporting documentation to us on your behalf; and
6. Clinical and financial assurances that you receive Medically Necessary and appropriate Covered Services under our Not-Billable Policy.

What is our "Not-Billable Policy"?

Charges for certain Services determined not to be Medically Necessary and appropriate may be "Not-Billable" to you or an

Enrolled Dependent. Delta Dental Providers may not collect on a Not-Billable Service. However, Non-Participating Dental Providers may collect from you on a Not-Billable Service. If in doubt, request a Prior Authorization on any proposed Service to assure the best oral health and financial outcomes for you and your Enrolled Dependents.

D. Non-Participating Dental Providers

When you receive Covered Services from a Non-Participating Provider, you will be reimbursed up to an out-of-network approved fee. Your Deductible, Copayment, and Coinsurance responsibilities are described in the Summary of Benefits, side-by-side with your In-Network Benefits.

In choosing a Non-Participating Dental Provider, you may be charged and financially responsible for the full Billed Amount set by the Non-Participating Provider and incur higher out-of-pocket costs. This situation is known as "***Balance Billing***" when a Non-Participating Dental Provider can charge and collect from you the full difference between the Billed Amount[1] and the lower out-of-network reimbursements for Covered Services. This can be a significant expense for you, especially if you have multiple Services.

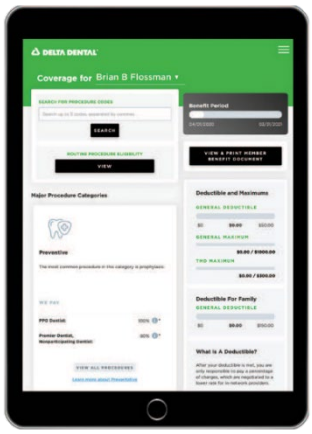
In contrast, Delta Dental Providers contractually agree to accept Approved Fees for Covered Services provided to you as payment in full. Delta Dental Providers cannot *Balance Bill* you if their Billed Amounts exceed contracted Approved Fees.

For these reasons, we encourage you to speak with the Non-Participating Provider to understand your potential financial responsibilities before receiving proposed Services. Requesting a voluntary Prior Authorization may also be good option to determine whether proposed Services are Medically Necessary and appropriate, covered, and what will be your estimated out-of-pocket responsibilities under the Plan. If you have questions or need assistance, contact our **Customer Service Team** toll free at **(877) 395-9420** or at **(505) 855-7111** Monday-Friday from 8 a.m.-4:30 p.m. MST. Automated system is available 24/7 or by email at **customerservice@deltadentalnm.com**.

Note: Under regulatory standards, a Non-Participating Provider will only be reimbursed at in-network levels if you have a Dental Emergency or no ability or opportunity to choose a Delta Dental Provider near you.

1 *See* "Billed Amount" definition in the Definition Section.

Member Portal



The Member Portal gives you easy, secure online access to benefits information 24/7. Visit the Member Portal at **deltadentalnm.com/Members/Member-Portal.aspx**. It offers you the ability to view Benefits, print ID cards, check Claims, and more. Simply log-in to your Member Portal to:

- Review coverage for Services;
- Find a Delta Dental Provider;
- Check on a Claims or Prior Authorization request;
- Understand your Deductible, Copay, or Coinsurance responsibility;
- Review an Explanations of Benefits (EOB);
- Download an ID Card; or
- Sign-up for paperless delivery of an EOB Statements.

E. Identification Cards

Your Delta Dental of New Mexico Identification ("ID") Card contains useful information such as your Group Number, Member ID Number, Group Name, and helpful contact information. You will not need to show your ID card to your Dental Provider to receive Services. Simply provide your name, birth date, and the Member ID Number or Social Security Number of the Subscriber to the dental office to verify coverage. You can access an ID card at **deltadentalnm.com/Members/Member-Portal.aspx**.

F. Utilization Review

Utilization Review is a vital component of managing your dental health and wellness. Delta Dental of New Mexico wants to ensure that you and your Enrolled Dependents receive quality Services to optimize your Benefits and dental health & wellness outcomes.

To protect you clinically and financially, a Delta Dental Consultant reviews the Services included with a Claim in relation to the Patient's clinical history to assure Medical Necessity and appropriateness under the Plan. So, please know the following:

1. All Claims with Utilization Review issues are automatically reviewed by a Delta Dental Consultant who is a New Mexico licensed and qualified dental professional; and
2. We may require additional information before approving Services included in a Claim.

The Utilization Review of Services helps us verify the diagnosis with generally accepted dental care standards, subject to applicable limits and exclusions. Requesting a voluntary Prior Authorization can be a good option to determine whether proposed Services are Medically Necessary and appropriate for you or

your Enrolled Dependent, as well as give you a line of sight on your potential financial obligations. *See* Section V for more information.

G. Emergency Dental Care

A Dental Emergency may come in many forms, and some situations are more urgent than others. Often, you may be hesitant to call your Dental Provider in a Dental Emergency as you may be unsure if the situation warrants Emergency Dental Care or if treatment will be covered. This Section will help answer these questions and provide you with guidance if you should face a Dental Emergency.

1. *What is a "Dental Emergency"?*

   A *Dental Emergency* means a potential life-threatening dental condition requiring immediate treatment to stop on-going tissue bleeding, alleviate severe pain or infection, and includes:

   a. Uncontrolled bleeding;

   b. Cellulitis or a diffuse soft tissue bacterial infections with intra-oral or extra-oral swelling that potentially compromise a patient's airway; or

   c. Trauma involving facial bones, potentially compromising the patient's airway.

2. *What is "Emergency Dental Care"?*

   Emergency Dental Care means dental care procedures, treatments, or services delivered to you or your Enrolled Dependent after the sudden onset of what reasonably appears to be a Dental Emergency. This includes, but is not limited to, emergency clinical oral examinations and emergency palliative treatment of dental pain. For instance, you may be in a situation where you experience severe pain or excessive swelling or bleeding that cannot be controlled. You may have suffered a severe dental injury or trauma that you may reasonably believe to be life threatening or require immediate treatment to stop ongoing tissue bleeding or to alleviate severe pain or infection.

3. *Emergency Dental Care Guidance and Support.* In a Dental Emergency, you and your Enrolled Dependents have the following resources:

   a. Emergency Room. You should go to an Emergency Room if reasonable believe that you are in a Dental Emergency and need Emergency Dental Care, as defined above.

   b. Tele-Dental Services. Tele-Dental Services allow you and your Enrolled Dependents to virtually confer with a qualified and New Mexico licensed Dental Provider to:

      - answer your questions;
      - assess your situation;
      - advise you if you need Emergency Dental Care;
      - prescribe you with any necessary medication until you can schedule an appointment with a Dental Provider; or
      - schedule an appointment with a Delta Dental Provider.

Check with your Dental Provider to see if they offer Tele-Dental Services. As an alternative, if your regular provider is unavailable or does not offer Tele-Dental Services, Delta Dental of New Mexico offers a service through Teledentistry.Com at **teledentistry.com/delta-dental-new-mexico** or **(866) 693-5430** that is available to you and your Enrolled Dependents after business hours, holidays or weekends during Dental Emergencies.

c. Delta Dental Provider. You may contact your Delta Dental Provider to access and obtain Emergency Dental Care, which may depend upon your Delta Dental Provider's office protocol and availability.

d. Non-Participating Provider. You may contact and visit a Non-Participating Provider to obtain Emergency Dental Care, which may depend upon the Non-Participating Provider's office protocol and availability.

e. Customer Services. At any time, you may contact our Customer Services Team for assistance by calling us toll free at **(877) 395-9420** or at **(505) 855-7111** Monday-Friday from 8 a.m.-4:30 p.m. MST. Automated system is available 24/7.

4. Benefit limitations and cost-sharing for Emergency Dental Care rendered by a Non-Participating Provider shall be the same as if rendered by a Delta Dental Provider when you experience a Dental Emergency. If you receive emergency care for a covered Service and cannot reach a Delta Dental Provider, as judged by the perspective of a reasonable person in the same or similar circumstances or after prior authorization, we will reimburse you as if the care was provided by a Delta Dental Provider.

5. Prior Authorization is not required for Emergency Dental Care.

H. Prior Authorizations and Pre-Treatment Estimates

Before receiving Services, you and your Dental Provider may want to know if a Service is covered and what will be your out-of-pocket costs and overall financial responsibilities. We want to help you and your Dental Provider manage the financial aspects of Services and ensure that Services are appropriately covered. This Subsection describes everything you need to know to request a Prior Authorization.

1. Prior Authorization vs. Pre-Treatment Estimate - Same

   Dental Insurance can be confusing in how it uses terms such as predeterminations, pre-treatment estimates, pre-certifications, or prior authorizations. While other dental insurers may have different definitions, processes, and requirements for these terms, Delta Dental of New Mexico wants to make the process easy for you and your Dental Provider by treating these terms interchangeably and the same with the term Prior Authorization as described in this Section.

2. What is Prior Authorization?

   Prior Authorization means a process performed by Delta Dental of New Mexico to determine whether a proposed Service is a Covered Service, Medically Necessary and appropriate, and an estimation of your out-of-pocket costs under the Plan, as voluntarily requested by you or your Dental Provider.

3. A Prior Authorization is designed to answer the following questions:
   - Are you eligible to receive the proposed Service?
   - Is the proposed Service covered by the Plan?
   - Is the proposed Service subject to a Limitation under the Plan such as an Annual Maximum Limit, Lifetime Maximum Limit, or a Frequency Limit?
   - Is the proposed Service Medically Necessary and appropriate?
   - What is the level of any reimbursement for the proposed Service given the available information provided, the terms and conditions of the Plan, and Processing Policies?
   - What is the level of your Out-of-Pocket Expense related to the Deductible, Copays, or Coinsurance under the Plan?
   - What is the resulting balance given Billed Amount set by the Dental Provider?
4. Requesting a Prior Authorization

   Although you may request a Prior Authorization on your own, we recommend that you collaborate with your Dental Provider to complete and submit the Prior Authorization request. The request will need to include clinical information, such as procedure codes, tooth numbers, and other supporting information such as x-rays, photographs, or clinical assessments. Typically, this information must be obtained from your Dental Provider and can be difficult to understand on your own.

   Prior Authorization requests follow similar processes and guidelines as a Claim submission. An electronic submission is the fastest way to submit a Prior Authorization request. Hard copy mailed submissions remains an option by sending your Prior Authorization request and support information to us at the following address:

   Delta Dental Plan of New Mexico
   Attn: Customer Services – Prior Authorization
   100 Sun Avenue NE, Suite 400
   Albuquerque, NM 87109

   If you have any questions or need any assistance, contact our **Customer Services Team** toll-free at **(877) 395-9420** or **(505) 855-7111**. Monday-Friday from 8 a.m.-4:30 p.m. MST. or by email at **customerservice@deltadentalnm.com** if you have questions or need assistance.
5. Advantage of using a Delta Dental Provider?

   Delta Dental Providers can use our *Dental Office Toolkit*. If the proposed Service **does not** require Utilization Review, a Delta Dental Provider can submit your Prior Authorization request through the *Dental Office Toolkit* while you are at the dental office and receive answers in real-time so that you can discuss the proposed Services with your Delta Dental Provider right away.

6. Timeliness of Review and Decision

   Once we receive your complete Prior Authorization request, we will make a decision within 5 business days and notify you and your Dental Provider. If we are unable to make a Prior Authorization determination with the information provided, we will send you and your Dental Provider a request for supplemental information.

   Note that if we deny a request for prior authorization, we will deliver to you a written explanation of the basis for the denial within 24 hours of the determination for emergency care and within 10 calendar days for all other care.

7. Payment Guarantee

   Our approval of your Prior Authorization guarantees coverage and reimbursement if your medical condition, coverage, or utilization does not change. We may only deny a Prior Authorization request for one of the following reasons:

   a. You utilized your Benefits with the same or another Dental Provider for any other Services and fulfilled your annual Maximum Limit or Frequency Limit;

   b. Your medical condition has changed due to natural causes, or because you received Services, and the proposed Services are no longer Medically Necessary or appropriate;

   c. Your Plan changed or you or your Enrolled Dependent are no longer eligible to receive Benefits;

   d. Another dental insurer is responsible for the Services or has already paid for the Services;

   e. The documentation submitted after the Service is performed does not match the approved information prior to the Service; or

   f. There is fraudulent or intentional misrepresentation activity.

8. Review of Decision

   If you or your Dental Provider has questions or is dissatisfied with a Prior Authorization determination, contact our Customer Services Team toll free at **(877) 395-9420** or at **(505) 855-7111** Monday-Friday from 8 a.m.-4:30 p.m. MST. or by email at **customerservice@deltadentalnm.com**. Most of the time, we can answer your questions, provide information, address your issues, and correct errors quickly. If you remain dissatisfied, you may request a formal review and appeal of a Prior Authorization determination under our "Adverse Determination" process as described below.

I. Out-of-Pocket Expenses

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

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

2. **Coinsurance.** Coinsurance is the percentage of Covered Services that the Enrolled Person is responsible for paying to the dental Provider. The amount of patient Coinsurance will vary depending on the level of Benefits for the particular dental treatment and the selection of a Participating or a Non-Participating Provider as described in the accompanying Summary of Benefits.
3. **Maximum Benefit Amount.** Delta Dental will pay for Covered Services up to a maximum amount for each Enrolled Person for each Benefit Period. Enrolled Persons are responsible for payment of amounts due for any dental services that exceed the Maximum Benefit Amount applicable in the Benefit Period. The Maximum Benefit Amount is stated in the Summary of Benefits.

III. Claims – Reimbursement of Covered Benefits

A. Claims - Generally

To use the Benefits under the Plan, a Claim must be filed with Delta Dental of New Mexico. A Claim is a request (with supporting records and information) for the reimbursement of Services provided by a Dental Provider. The Claim must include necessary information and documentation, such as treatment details and costs, so that we can determine coverage, Medical Necessity & appropriateness, and reimbursement in accordance with the Plan, any agreement that we may have with a Dental Provider, and other applicable requirements. The Dental Provider typically includes their Billed Amount for Services that are set by the Dental Provider and vary from Dental Provider to Dental Provider.

This Section explains:

- How to file a Claim to obtain Benefits;
- How the Claim will be processed; and
- What you can do if you have questions, concerns, complaints, or grievances about an action taken on a Claim.

THIS SECTION DOES NOT, IN ANY WAY, IMPLY THAT FILING A CLAIM OR AN APPEAL WILL RESULT IN BENEFIT PAYMENT OR EXEMPT YOU FROM COMPLYING WITH THE TERMS AND CONDITIONS OF THE PLAN.

Our Claim processes are also designed to help you and your Dental Provider manage the financial aspects of Services and ensure that Services are appropriately covered under this Plan. We will process submitted Claims according to the eligibility and Benefits at the time that Services are provided. Regardless of where Services are received, you must meet all Plan requirements or Benefits may be denied.

Know that coverage for you or any Enrolled Dependents shall be terminated retroactively to the Effective Date if you commit fraud or make a material misrepresentation in applying for or obtaining coverage or Benefits. Coverage shall also terminate immediately if you or your Enrolled Dependent files a fraudulent Claim.

B. Claim Filing

1. Claim Filing Deadline

   All Claims must be filed within **12 months** from the date that Services were provided. Failure to submit a Claim within this timeframe shall not void or reduce the Claim if it shown that it was not reasonably possible for you to submit the Claim within the 12-month period. Upon review, we will make a final determination.

2. Delta Dental Provider

   If you use a Delta Dental Provider, they will file the Claim for you and payment will be sent directly to them. You will receive an Explanation of Benefits ("EOB") from us.

3. Non-Participating Provider

   If you use a Non-Participating Dental Provider, they may file the Claim for you or require you to file the Claim with us as outlined in Subsection D below.

   Note that Delta Dental of New Mexico may send payment directly to the Non-Participating Provider if you designate and attest to direct payment to the Non-Participating Provider on the Claim Form. The Non-Participating Provider must cooperate and coordinate with us to make the direct payment under your designation, otherwise payment will be made to you. You will receive an EOB indicating whether we sent payment to you or the Non-Participating Provider.

   As stated above, you should be aware that any payments made to a Non-Participating Provider for Covered Services may result in higher Out-of-Pocket Expenses to you. The Non-Participating Provider may also Balance Bill you for Billed Amounts that exceed Allowable Amounts.

C. How You may File a Claim

1. Claim Forms

   As a condition of payment, Delta Dental of New Mexico requires the submission of a Claim Form. Most Dental Providers will file a Claim with us on your behalf by using a Claim Form.

   If you need to file your own Claim, you can access a Claim Form by logging into the **Member Portal** at **deltadentalnm.com/Members/Member-Portal.aspx**. You can also request a Claim Form by calling our **Customer Service Team** Toll-Free at **(877) 395-9420** or **(505) 855-7111** Monday-Friday from 8 a.m.-4:30 p.m. MST or by sending an email to **customerservice@deltadentalnm.com**.

   Delta Dental of New Mexico will provide you with a Claim Form within 15 days of receiving notice of a claim from you in the manner that you request. If we do not furnish the Claim Form within 15 days, then you shall be deemed to have complied with the requirement to provide proof of loss if the notice of claim contains written proof describing the Claim, including the character and extent of the loss of which the Claim is made. Adequate proof of loss must be in our possession at the time funds are disbursed in the payment of the Claim.

2. Completing Claim Forms and Itemized Bills

All information on the Claim Form and itemized statements must be readable. If information is missing or not readable, then we will return it to you or your Dental Provider. Handwritten entries added to a typed or electronic Claim Form that change or add procedure codes will require you or your Dental Provider's signatures acknowledging approval.

The information on itemized bills is used to determine Benefits, so it must support information reported on your submitted Claim Form. All Claims must include:

- Subscriber's ID Number or Social Security Number;
- Subscriber's name and address;
- Patient's name;
- Patient's age and relationship to the Subscriber;
- Other dental insurance coverage in effect;
- Date of Service;
- Type of Treatment;
- CDT Codes;
- Tooth Numbers and Quadrants (if applicable);
- Itemization of charges;
- Accident or surgery date (if applicable);
- Name and address of the Dental Provider;
- Dental Provider's Tax ID Number or Social Security Number;
- Patient's signature; and
- Dental Provider's signature.

If an itemized bill is not attached to the Claim Form, the Dental Provider must complete the "Dental Provider Information Section" or provide a treatment statement and must sign the Claim Form.

Note: Benefits cannot be determined if documentation is missing or radiographs submitted are of insufficient diagnostic quality to determine Benefits.

3. *Separate Claim Forms Required*

   A separate Claim Form is required for each Dental Provider for which you are requesting reimbursement. A separate Claim Form is also required for you when charges for Enrolled Dependents are being submitted.

4. *Other Valid Dental Coverage*

   If this Plan is secondary to other dental insurance coverage, you will need to file your Claim with the other insurance carrier first. *See* Coordination of Benefits Section for more information. If a Dental Provider normally files Claims with Delta Dental of New Mexico and the other insurer does not pay the Dental Provider directly, then you will need to provide the Dental Provider

with a copy of the other insurance carrier's Explanation of Benefits (EOB) to include with the Claim Form sent to us. If a Non-Participating Provider does not file Claims for you, you will need to attach a copy of the Non-Participating Dental Provider's EOB to the Claim Form that you send to us.

5. *Out-of-Country Claims*

   You are responsible for filing Claims for any Services that you receive outside of the United States of America. You must complete a Claim Form. For instance, under the "Patient Section" of the Claim Form, you must complete an itemization of Services that includes:

   - The name, address, and contact information of the Dental Provider and Clinic or Office;
   - The tooth number or area of the oral cavity (if applicable);
   - A description of each individual Service provided;
   - The date of Service;
   - The fee for each individual Service; and
   - The Dental Provider's signature.

   In reviewing the out-of-country Claim, we may ask you to provide a signed attestation and acknowledgment that you received the specified Services.

   You must also provide an itemized receipt(s) that indicates the country's currency. We calculate foreign currency Benefit payments based on published currency conversion tables that correspond to the date of service. Contact our **Customer Services Team** toll-free at **1-877-395-9420** or **(505) 855-7111** Monday-Friday from 8 a.m.-4:30 p.m. MST. or send an email to **customerservice@deltadentalnm.com**, if you have questions or need assistance.

   If the Services performed outside of the USA are for extractions, crowns, bridges, dentures, or partial dentures, a radiographic image of the area **must** be obtained prior to the Service and must be submitted with the claim form in order to be considered for Benefits.

   You are responsible for: (1) obtaining the necessary receipts, records, itemization, and documentation for the Services provided; (2) filing the Claim with us; and (3) paying the Dental Provider at the time the Services are performed.

6. Where to file Claims

   Completed Claims Forms, itemized bills, and other required documents may be submitted to us by email at **customerservice@deltadentalnm.com** or by mail at the following address:

   Delta Dental Plan of New Mexico
   Attn: Customer Services – Claims
   100 Sun Avenue NE, Suite 400
   Albuquerque, NM 87109

If you have any questions or need any assistance, contact our **Customer Services Team** toll-free at **(877) 395-9420** or **(505) 855-7111** Monday-Friday from 8 a.m.-4:30 p.m. MST or by email at **customerservice@deltadentalnm.com**.

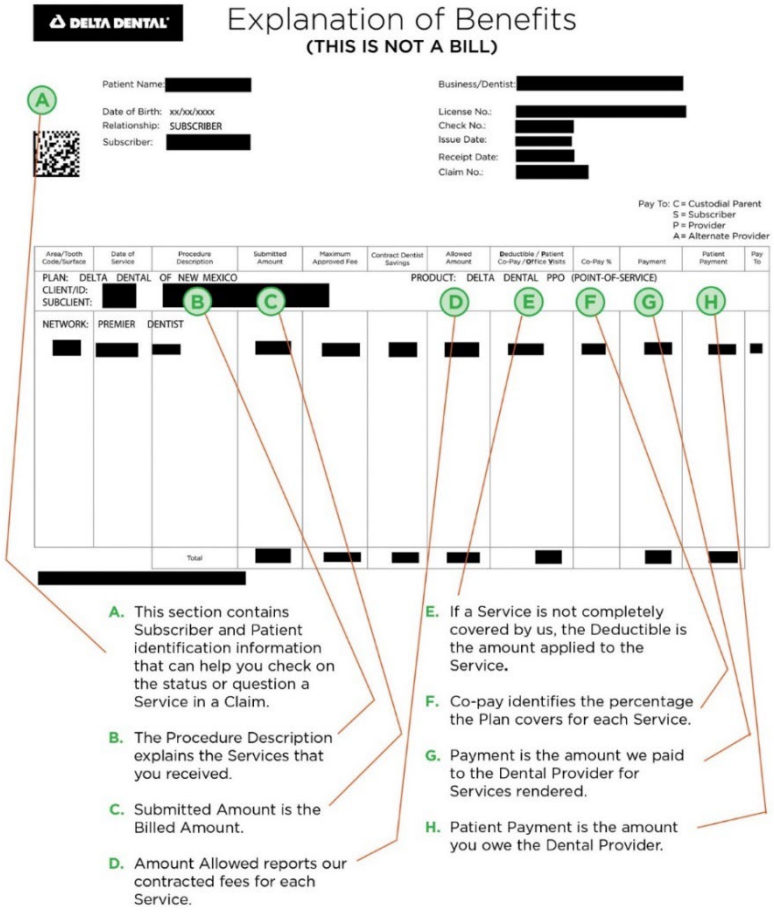
D. Claim Processing

1. When we receive a Claim, we review each line of service and related billed amounts, verify coverage, Medical Necessity and appropriate, and determine the appropriate level of coverage and any reimbursement under your coverage, any agreement that we may have with the Dental Provider, and other applicable requirements.
2. We will pay all Claims for Covered Services within **30 days** of our receipt of all information required to process the Claim ("*Complete Claim*"). This 30-day period may be extended by an additional 15 days if matters beyond the control of Delta Dental of New Mexico delay Benefit determination. Notification of any necessary extension will be sent prior to the expiration of the initial 30-day period.
3. If the Employer Group does not pay the required Premium, all Claims for you or your Enrolled Dependents will be placed on hold.
4. If the Claim is denied in whole or in part, you will receive a notice from us with:
    a. the reason for the denial;
    b. a reference to the legal or contractual authority on which the denial is based;
    c. An explanation on how you may have the Claim reviewed by us if you are dissatisfied with an Adverse Determination or Administrative Decision; and
    d. Additional information as required by law or to provide you with service and support

E. Explanation of Benefits (EOB)

Each time you visit a Dental Provider, you will receive an Explanation of Benefits ("EOB") following the visit. This document is **NOT** a bill but provides you with a breakdown of your Benefits and the Services that you received. The EOB will provide you with our Benefit determination, any payment made by us, and any amount still owed to the Dental provider.

If you are having trouble understanding your EOB, use this guide.



F. To Whom Benefits Are Paid

1. We agree to make payments for Covered Services provided to you and your Enrolled Dependents as described in this Dental Benefit Handbook and the Summary of Benefits.
2. We will pay a Delta Dental Provider directly for Covered Services rendered. You and your Enrolled Dependents are responsible for paying the Delta Dental Provider directly for any Deductible, Copayment, Coinsurance, and for any non-covered Services.
3. We will pay a Non-Participating Dental Provider directly when you or your Enrolled Dependent designates and attests to direct payment to the Non-Participating Dental Provider on the Claim Form. Note that the Non-Participating Dental Provider will need to cooperate and coordinate with us to make the direct payment under your designation, otherwise payment will be made to you. You will receive an EOB indicating whether we sent payment to you or the Non-Participating Dental Provider.
4. All available Benefits not paid to a Dental Provider shall be payable to the Enrolled Person or to the estate of the Enrolled Person.

G. Right to Recover Benefits Paid by Mistake

Delta Dental of New Mexico has the right to recover any Claim payment made by us in error within 24 months from the date that we paid the Claim from the Dental Provider. Erroneous Claim payments may include Claims paid by us:

1. for Services not actually covered under your Plan;
2. for Services inaccurately submitted or coded by the Dental Provider;
3. exceed Annual Maximum Limit or Lifetime Maximum Limit of the Plan; or
4. based upon fraud or an intentional misrepresentation.

We may seek recovery of any Claim payments made in error from: anyone, for or to whom such payments were made; or any insurer or organization that provides other coverage for any Covered Expenses. We will determine from whom we shall seek recovery. For more information, *see* Section VII(E) of this Plan.

Know that a correction may result in an adjustment to any amount applied to your Deductible, Annual Maximum Limit, or Lifetime Maximum Limit.

H. Customer Services

We are always here to listen and help you. If you have a question, issue, or concern, call the **Customer Service Team** at **(505) 855-7111** or toll free at **(877) 395-9420** Monday-Friday from 8 a.m.-4:30 p.m. MST. Our Customer Service Team is ready to answer your questions, listen to your concerns, gather information, provide explanations, and resolve issues quickly. If you want to provide us with your question or concern in writing, you can call or write to us at:

Delta Dental of New Mexico
Attn: Customer Services
100 Sun Avenue NE, Suite 400
Albuquerque, NM 87109
toll free **1-877-395-9420** | **1-505-855-7111**

customerservice@deltadentalnm.com

There is also helpful information and services through our website at **deltadentalnm.com**. We will do our best to answer your questions and address your issues and concerns as soon as possible, but in any case, within **30 days**. If you are dissatisfied with the results, you can request a formal internal review or appeal under the procedures described in Section VI.

IV. Benefits, Limitations, and Exclusions

This Section describes the standard Benefits covered by the Plan subject to your Summary of Benefits. Unless stated otherwise in the Summary of Benefits, the following Benefits, Limitations, and Exclusions apply to this Plan. Note that any Service will be considered for Benefits based on the date the Service is received.

Benefits are subject to the Processing Policies of Delta Dental of New Mexico and the terms and conditions of this Plan. Refer to the accompanying Summary of Benefits for applicable Deductible, Copay, and Coinsurance amounts. In addition to the Limitations applicable to each type of Service, refer to "General Limitations and Exclusions" Subsection.

TO THE EXTENT THAT ANYTHING SET FORTH IN THIS EVIDENCE OF COVERAGE CONFLICTS WITH YOUR SUMMARY OF BENEFITS, YOUR SUMMARY OF BENEFITS WILL CONTROL.

A. Types of Expenses

The following Out-of-Pocket expenses may apply to your Plan:

4. Deductible

   The Plan may require you or your Enrolled Dependent to pay a portion of the initial expense toward some Covered Services in each Benefit Period. When applicable, the amount of this Deductible is set in your Summary of Benefits.

5. Co-Insurance

   Co-Insurance is the percentage of Covered Services that you or your Enrolled Dependent is responsible for paying to the Dental Provider. The Co-Insurance amount will vary depending upon the level of Benefits for the particular Services and whether you select a Delta Dental Provider or a Non-Participating Provider, as described in your Summary of Benefits.

6. Maximum Benefit Amount

   We will pay for Covered Services up to the Annual Maximum Limit or Lifetime Maximum Limit for you and each Enrolled Dependent for each Benefit Period. You and your Enrolled Dependent are responsible for the payment of amounts due for any Covered Services that exceed the Maximum Benefit Amount applicable in the Benefit Period. The Annual Maximum Limit or Lifetime Maximum Limit are stated in your Summary of Benefits.

B. Diagnostic and Preventive Services

1. Diagnostic Services mean procedures to aid a Dental Provider in choosing the required and appropriate dental treatment such as Patient screenings, oral

examinations, diagnostic consultations, diagnostic casts, clinical oral evaluations, and radiographic images. The Summary of Benefits provides detailed coverage information, but the Plan shall, at a minimum, cover the following Diagnostic Services with no waiting period:

a. One (1) clinical oral examination twice per Benefit Period

b. Clinical oral examination twice per year.

2. Palliative Services mean Emergency Dental Care for the sole purpose of temporarily relieving pain in combination with Diagnostic Services only.

3. Radiology Services. The Plan shall, at a minimum, cover the following Radiology Services with a waiting period of no longer than six consecutive months:

   a. Bitewings are payable twice per benefit period with a limit of two (2) Bitewing images for children under age 10;

   b. Panoramic films or an intraoral-complete series are payable once every five consecutive years.

4. Preventive Services mean brush biopsy and related lab tests, cleanings, application of topical fluoride, space maintainers, and sealants. The Summary of Benefits provides detailed coverage information, but the Plan shall, at a minimum, cover the following Preventative Services with no waiting period:

   a. Prophylaxis. Two (2) prophylaxis services every Benefit Period

   b. Fluoride Treatment. At least one (1) fluoride treatment per Benefit Period in a healthcare setting for children up to 14 years old or older as Medically Necessary.

   c. Molar Sealants. One (1) treatment of molar sealant per tooth every five (5) consecutive years as Medically Necessary and appropriate. Coverage is excluded where an occlusal restoration has been completed on the tooth. A waiting period of six (6) consecutive months applies for Medically Necessary and appropriate sealants.

C. Limitations on Diagnostic and Preventive Services

1. Benefit for patient prediagnostic screenings is limited to once in a Benefit Period. A separate fee for patient assessment is not billable to the Patient.

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 not billable to the Patient when submitted for children under the age of three (3).

   b. A separate fee for a caries risk assessment is not billable to the Patient 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 not billable to the Patient when the procedure is performed in addition to any other risk assessment

procedure on the same date of Service by the same Dental Provider or dental office.

3. Blood glucose level tests and HbA1c tests are not Covered Services.
4. Assessment of salivary flow by measurement is a Benefit once every thirty-six (36) months. Subsequent submissions are not billable to the Patient within twelve (12) months and not a Benefit at twelve (12) to thirty-six (36) months.
5. Brush biopsies are limited to once in a twelve (12) month period. A separate fee for interpretation is not billable to the Patient.
6. Benefits for oral examinations, including diagnostic consultations, emergency or re-evaluation exams, clinical oral evaluations, routine cleanings, and topical fluoride treatment are limited as shown in the Summary of Benefits.
7. Enrolled Persons under the age of fourteen (14) are limited to routine child cleanings. Enrolled Persons age fourteen (14) and over will be considered adults for the purpose of determining Benefits for cleanings.
8. Delta Dental of New Mexico will reimburse a complete series of radiographic images as provided in the Summary of 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 are subject to Utilization Review. Bitewing radiographic images exceeding the diagnostic equivalent of a complete series of radiographic images are subject to Utilization Review when taken on the same date of Service.
9. Emergency Dental Care palliative treatment does not include Services that exceed the minor treatment of pain. This Benefit is limited to radiographic images and tests necessary to diagnose a Dental Emergency condition.
10. Services for diagnostic casts, oral/facial photographic images, laboratory and diagnostic tests, non-routine diagnostic imaging, non-surgical collection of specimens, oral hygiene instruction, home fluoride, mounted case analysis, and nutrition or tobacco counseling are not covered. A separate fee for image interpretation is Not Billable to the Patient.
11. Pulp tests are a Benefit per visit, not per tooth, and only for the diagnosis of a Dental Emergency condition. Fees for pulp tests are Not Billable to the Patient as part of any other definitive procedure on the same day by the same Dental Provider or dental office except for limited oral evaluation (problem focused), palliative treatment, radiographic images, and protective restorations.
12. Benefits for sealants are limited to permanent molars. Sealants are a Covered Service for Enrolled Persons as stated in the Summary of Benefits.
13. A separate fee for the replacement or repair of a sealant by the same Dental Provider or dental office is Not Billable to the Patient within two (2) years of the initial placement.
14. An age limitation may apply to Services related to space maintainers. Refer to the Summary of Benefits for applicable age limitations.

15. Fixed bilateral space maintainers are payable once per arch per lifetime for a Patient up to age fourteen (14).
16. Fixed unilateral, removable unilateral, and removable bilateral space maintainers are payable once per quadrant per lifetime for a Patient up to age fourteen (14).
17. A separate fee for the removal of a space maintainer by the same Dental Provider or dental office who placed the initial appliance is Not Billable to the Patient. Removal of a space maintainer by a different Dental Provider or dental office is a Benefit once per appliance per lifetime.
18. Benefits for distal shoe space maintainers are payable once per area per lifetime for a Patient up to age of nine (9) years old.
19. A separate fee for the repair or adjustment of a distal shoe space maintainer by the same Dental Provider or dental office who placed the initial appliance is Not Billable to the Patient.
20. A separate fee for the recementation, re-bond, or repair to a space maintainer by the same Dental Provider or dental office is not billable to the Patient within six (6) months of the original treatment. Six (6) months after the original treatment date, recementation, re-bond, or repair is a Benefit once per appliance.
21. Interim caries arresting medicament application is limited to twice per tooth per Benefit Period.
22. Preventive restorations are not a Benefit.
23. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

D. Additional Benefits for Patients with Specified Medical Conditions

Delta Dental of New Mexico may pay for additional Benefits for a Patient with specified medical conditions. We reserve the right to request additional chart notes and information from your treating medical provider to approve the additional benefits.

1. Patients with the following medical conditions may be eligible for additional cleanings, up to four (4) total cleanings per Benefit Period:
    a. Diabetes with periodontal disease;
    b. Pregnancy with periodontal disease;
    c. Renal failure/dialysis;
    d. Suppressed immune system due to but not limited to chemotherapy/radiation treatment, HIV positive, organ transplants, and stem cell (bone marrow) transplants;
    e. Head and neck radiation; or
    f. Patients at risk for infective endocarditis.
2. Qualifying Heart Conditions are:

a. History of infective endocarditis;

b. Certain congenital heart defects (ex. one ventricle instead of the normal two);

c. Patients with artificial heart valves;

d. Heart valve defects caused by acquired conditions like rheumatic heart disease;

e. Hypertrophic cardiomyopathy (causes abnormal thickening of the heart muscle);

f.Patients with pulmonary shunts or conduits; or

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

3. In addition, head and neck radiation Patients may also be eligible for additional topical fluoride treatments, up to two (2) total topical fluoride treatments per Benefit Period.
4. It is important that a Patient notify their Dental Provider of these or any other serious medical conditions and to discuss what treatment options may be right for the Patient.
5. An Enrolled Person must be able to submit to Delta Dental of New Mexico a documented diagnosis of any of the above conditions to qualify for additional procedures.

E. Restorative Services

Restorative Services mean amalgam, resin-based composite restorations (fillings), or stainless steel and prefabricated stainless-steel restorations. Restorative Services are a Benefit for the treatment of visible destruction of the hard tooth structure resulting from the process of decay or injury. Fillings for cavities shall be covered as Medically Necessary and appropriate with no waiting period.

F. 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 Dental Provider or dental office is Not Billable to the Patient 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 stated otherwise in the Summary of 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 Utilization 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 not billable to the Patient. A separate fee for the replacement of pin retention on the same tooth, by the same Dental Provider or dental office, within twenty-four (24) months is Not Billable to the Patient.
9. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

G. Basic Services

1. Anesthesia includes intravenous sedation and general anesthesia.
2. Endodontics includes the treatment of teeth with diseased or damaged nerves, such as root canals.
3. Extractions includes surgical extractions. The 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.
4. Oral Surgery includes oral maxillofacial surgical procedures of all hard and soft tissue of the oral cavity.
5. Periodontics includes the treatment of diseases of the gums and supporting structures of the teeth.

H. Limitations on Basic Services

1. Evaluation for deep sedation or general anesthesia is Not Billable to the Patient when billed in conjunction with an evaluation by the same Dental 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 Dental Provider in conjunction with specified surgical procedures, subject to Utilization Review and when Medically Necessary and appropriate.
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 Not Billable to the Patient for pulp therapy procedures when performed on the same day, by the same Dental Provider or dental office, as other surgical procedures involving the root.

7. A separate fee is Not Billable to the Patient 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 Dental Provider or dental office.
8. A pulpotomy or pulpal debridement is a Benefit once per tooth per lifetime.
9. Placement of an intra-socket biological dressing to aid in hemostasis or clot stabilization, per site, is considered part of the extraction and/or post-operative procedure. A separate fee is Not Billable to the Patient.
10. 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.
11. Root canal therapy in conjunction with overdentures is not a Benefit.
12. Re-treatment of root canal therapy or re-treatment of surgical procedures involving the root, by the same Dental Provider or dental office, within twenty-four (24) months, is considered part of the original procedure and a separate fee is Not Billable to the Patient.
13. Apexification Benefits are limited to permanent teeth, once per tooth per lifetime. This procedure is Not Billable to the Patient if performed by the same Dental Provider or dental office within twenty-four (24) months of root canal therapy.
14. Endodontic endosseous implants are not a Benefit.
15. Tooth transplantation, including re-implantation, is not a Benefit.
16. Scaling in the presence of generalized moderate or severe gingival inflammation is considered to be a cleaning for Benefit frequency determination.
17. Periodontal maintenance is a cleaning for Benefit frequency determination. Benefits for periodontal maintenance are limited as shown in the Summary of Benefits.
18. A separate fee for periodontal maintenance may be Not Billable to the Patient within 3 months of other periodontal therapy provided by the same Dental Provider or dental office, as determined by Utilization Review.
19. Full mouth debridement is only a Benefit when necessary to enable comprehensive evaluation and diagnosis on a subsequent visit and is limited to once per lifetime.
20. Periodontal scaling and root planing are a Benefit once per quadrant or site in a two (2) year period.
21. Localized delivery of antimicrobial agents may be performed at six weeks to six months after initial therapy (scaling and root planing or surgery) on no more than two sites per quadrant, with pocket depth at least five millimeters and less than ten millimeters.
    a. If different teeth are treated in the quadrant within twelve 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.

22. Periodontal surgeries, such as gingivectomy, gingival flap, osseous surgery, bone grafts, and tissue graft procedures are limited to once per site in a three-year period.
23. Gingivectomy or gingivoplasty to allow access for a restorative procedure is considered part of the restorative procedure.
24. 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 not a Benefit.
25. 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.
26. Separate fees for crown lengthening in the same site are not billable to the Patient when charged by the same Dental Provider or dental office within three years.
27. Additional fees for more than two quadrants of osseous surgery on the same date of Service are Not Billable to the Patient.
28. Separate fees for postoperative visits and/or dressing changes by the same Dental Provider or dental office performing the treatment are Not Billable to the Patient.
29. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

I. Major Services

NO PAYMENT WILL BE MADE BY DELTA DENTAL OF NEW MEXICO FOR MAJOR SERVICES UNLESS STATED OTHERWISE IN THE SUMMARY OF BENEFITS.

1. Crown Build-Ups and Substructures are Benefits when necessary to retain a cast restoration due to extensive loss of tooth structure from caries, fracture, or endodontic treatment.
2. Crowns and Cast Restorations, Including Repairs to Covered Procedures are Benefits when a tooth is damaged by decay or fractured to the point that it cannot be restored by an amalgam or resin filling.
3. **Implants** includes 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.
4. **Prosthodontics** includes Services for the construction, modification, or repair of bridges and partial or complete dentures.

J. 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.
4. Replacement of a bridge or denture is not a Benefit if the previous placement is less than five 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 Utilization 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 Not Billable to the patient when enough tooth structure is present to retain a cast restoration.
9. The fee for a core build-up and/or substructures is not billable to the Patient when performed in conjunction with inlays, onlays, ¾ crowns, and veneers.
10. Posts and cores in addition to a crown are a Benefit only on endodontically treated teeth. In addition to the requirement for endodontic treatment, anterior teeth must have insufficient tooth structure to support a cast restoration. Fees are Not Billable to the Patient 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 months of the original treatment by the same Dental Provider or dental office is Not Billable to the Patient.
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 Dental Provider or dental office is Not Billable to the Patient.
13. Services for the recementation, re-bond, or repair of 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.
14. 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.

15. Surgical placement of an implant body is a Benefit once per tooth per five (5) year period.
16. Implant supported prosthetics and/or abutment supported crowns are not a Benefit if the previous placement is less than five years old. This limitation applies to the placement of crowns on natural teeth, abutment supported crowns on implants, and fixed partial denture pontics.
17. Implant maintenance procedures are limited to twice in a Benefit Period.
18. 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 Not Billable to the Patient 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 Dental Provider or dental office within twenty-four months of initial therapy is Not Billable to the Patient.
    d. A separate fee is Not Billable to the Patient when this procedure is performed within twelve months of implant-supported crown or bridge procedures by the same Dental Provider or dental office.
19. 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.
20. A separate fee for the removal of an implant within twenty-four months of the original placement, by the same Dental Provider or dental office, is Not Billable to the Patient. After twenty-four months, this service is a Benefit once per tooth per lifetime.
21. A separate fee is Not Billable to the Patient for a radiologic surgical implant index.
22. 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.
23. Temporary restorations, temporary implants, and temporary prosthodontics are considered part of the final restoration. A separate fee by the same Dental Provider or dental office is Not Billable to the Patient.
24. 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.
25. Maxillofacial prosthetics and related services are not a Benefit.
26. Crowns, implants, prosthodontics, and all related services are not Benefits for Patients under the age of sixteen.

27. Fees for full or partial dentures include any reline/rebase, adjustment, or repair required within six months of delivery except in the case of immediate dentures. After six months, adjustments to dentures are a Benefit twice in a twelve-month period and relines or rebases are a Benefit once in a three-year period.
28. Tissue conditioning is not a Benefit more than twice per denture unit in a three-year period.
29. Treatment of Temporomandibular Joint Dysfunction (TMD) is not a Benefit.
30. An occlusal guard is a Benefit once per lifetime.
31. An occlusal adjustment is a Benefit. A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
32. Non-invasive TMD physical therapies are not Covered Services.
33. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

K. Orthodontic Services

No payment will be made by Delta Dental for Orthodontic Services or related services under this Plan unless otherwise specified in the Summary of Benefits. If Orthodontic Services are a Benefit under your Summary of Benefits, the treatment must occur under supervision of a Dental Provider. Delta Dental of New Mexico does not cover or reimburse for home-based or self-applied orthodontic treatments.

L. Tele-Dental Services

Tele-Dental Services are counted as a problem-focused examination and covered as an in-network service. Tele-Dental appointments can assess a Patient's situation, prescribe medication, advise the Patient that Emergency Dental Care is necessary, or assist a Patient in scheduling an appointment. A Tele-Dental visit does not count as a regular preventative oral exam.

M. General Limitations and Exclusions

1. A Benefit waiting period prior to obtaining some Services applies if stated in the Summary of Benefits. This means an Enrolled Person is not eligible for Benefits for those services until the Enrolled Person has been continually enrolled under this Plan for the time frame stated in the Summary of Benefits.
2. Services for any Covered Services that exceed the frequency or age limitation shown in the Summary of Benefits are not eligible for Benefits. Unless stated otherwise, all frequency limitations are measured from the last date a procedure was performed according to the Patient's dental records.

3. If dental standards indicate that a condition can be treated by a less costly alternative to the Service provided by a Dental Provider, the Plan will pay Benefits based upon the less costly Service.
4. Services beyond treatment considered the standard of care customarily provided are considered "Optional or Specialized Services" that may include the use of alternative techniques, special materials, and Services of a cosmetic intent. If an Enrolled Person receives Optional or Specialized services, Benefits may be provided based on the customary or standard procedure. A determination of Optional or Specialized services is not an opinion or judgment on the quality or durability of the Service. The Enrolled Person will be responsible for any difference between the cost of Optional or Specialized Services and any Benefit payable.
5. Charges for cone beam CT capture and interpretation services are not a Benefit.
6. 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.
7. Treatment to restore tooth structure lost from wear is not covered.
8. Cosmetic surgery or procedures are not covered.
9. Prosthodontic services or any single procedure started before the Patient is covered under this Plan is not eligible for Benefits.
10. Prescribed drugs, pain medications, desensitizing medications, and therapeutic drugs are not covered.
11. 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.
12. A separate fee for a consultation with a medical care professional is not billable to the Patient.
13. A separate fee for certified translation or sign language services is not billable to the Patient.
14. Dental Case Management Services are subject to these limitations and/or exclusions:
    a. A separate fee for addressing appointment compliance barriers is not billable to the Patient.
    b. A separate fee for care coordination is not billable to the Patient.
    c. Motivational interviewing is not a Benefit.
       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 not billable to the Patient.
    d. Patient education to improve oral health literacy is not a Benefit.
       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 not billable to the Patient.

15. Orthodontic Services, or any Services related to an orthodontic treatment plan, are not covered unless stated otherwise in the Summary of Benefits.
16. Treatment must be provided by a licensed Dental Provider who by law may work under a licensed Dental Provider's direct supervision.
17. A separate charge for office visits, non-diagnostic consultations, case presentations, or cancelled or missed appointments is not covered.
18. Administrative services including but not limited to the duplication or copying of records are not Covered Services.
19. Services to correct harmful habits is not covered.
20. A separate charge is not billable to the Patient for behavior management, infection control, sterilization, supplies, and materials.
21. Charges for Services that are not necessary according to accepted standards of dental practice are not Benefits.
22. Charges for Services that are not a Medically Necessary or appropriate are not Benefits. All Services must be Medically Necessary and appropriate. The fact that a Dental Provider may prescribe, order, recommend, or approve a Service does not, in itself, determine Medical Necessity.
23. Services, as determined by Delta Dental of New Mexico, that are Experimental or Investigational in nature are not covered including but not limited to Services required to treat complications from Experimental or Investigational procedures.
24. A hemi sectioned tooth will not be Benefited as two separate teeth.
25. Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion is not a Benefit.
26. Treatment to stabilize teeth is not a Benefit.
27. Occlusal or athletic mouth guards and related Services are not a Benefit.
28. Replacement of existing restorations (fillings) for any purpose other than treating active tooth decay or fracture is not covered. A *tooth fracture or crack* means tooth structure that is mobile and/or separated from the natural tooth structure.
29. Charges for treatment of craze lines are not a Benefit. A *craze line* means a visible micro-fracture located in coronal enamel that does not break or split the continuity of the tooth structure.
30. Home-based or self-applied orthodontic treatments are not a Benefit.
31. Sales tax is not a Benefit.

32. Separate fees are not billable to the Patient for Services that are routinely considered by us to be part of another Service, if performed by the same Dental Provider or dental office on the same date of service.
33. Services excluded by our policies and procedures, including but not limited to Processing Policies, are not a Benefit.
34. Services 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 of New Mexico coverage are not covered by the Plan.
35. Services received due to an act of war or terrorism, declared or undeclared, are not a Covered Service.
36. Services that are not covered under this Plan are not a Benefit.

V. Coordination of Benefits

Coordination of Benefits ("COB") applies when you or your Enrolled Dependent has more than one dental insurance plan. In such cases, you or your Dental Provider should file a Claim with both plans, so that the plans can coordinate covered benefits and reimbursement of the Claim.

When a COB situation happens, we must:

- Pay the Claim correctly by looking at all dental plans and benefits for you or your Enrolled Dependent who received Services;
- Figure out the priority of payments for the coordination of covered benefits between the dental plans; and
- Coordinate payments in a way that does not exceed the maximum limits or actual dental bills.

For these reasons, there is no guarantee that 100% of the charges for a Claim will be paid, even if you have more than one dental plan.

A. Cooperation

You and your Dental Provider are required to provide us with information about all dental plans, so that we can properly coordinate covered benefits and pay your Claim as required by law and this Evidence of Coverage. Please know that we may release or obtain required information to other dental plans to coordinate covered benefits and pay the Claim. It is important for you and your Dental Provider to submit the Claim with all dental plans so that everyone is aware of other coverages.

B. Coordination of Maximums and Duplications

Know that that each dental plan will have its own Annual Maximum Limit and Lifetime Maximum Limit ("Maximums"). In coordinating covered benefits, the combined covered benefits from the dental plans cannot exceed the higher of the two Maximums. Total benefits received from multiple dental plans also cannot exceed the actual dental expenses incurred. Note that any Deductibles, Copays, and Coinsurance amounts will be applied before Benefits are paid for a Claim.

C. Primary and Secondary Coverage

If you have multiple dental plans, one plan will be designated as the primary plan. The other dental plan will be considered the secondary plan. The primary plan shall pay covered benefits first, up to its coverage limits. The secondary plan shall pay any remaining eligible expenses for covered benefits Services based upon its coverage guidelines.

D. Determining the Primary Plan

To figuring out which dental plan is primary, we will consider whether you or your Enrolled Dependents are involved in the Claim and look at the COB provisions of the dental plans under the following rules:

1. *Medicaid, Medicare, or Indian Health Services Rule.* We will typically be the primary plan of any covered benefits payable by Medicaid, Medicare, or the Indian Health Services as follows:
    a. Medicare If any Enrolled Persons are enrolled in Medicare, then the Benefits provided by the Plan are not designed to duplicate any benefits that you or your Enrolled Dependents may be entitled to under the federal *Social Security Act*. Covered Benefits will be coordinated according to applicable federal law;
    b. Medicaid If You or your Enrolled Dependents are enrolled under the New Mexico Medicaid Program, then Benefits payable under this Plan will be paid to the New Mexico Human Services Department ("HSD"), or its successor or designee, when: (i) HSD has paid or is paying covered benefits on behalf of you or your Enrolled Dependent; or (ii) the payment for covered benefits has been made by HSD to the Medicaid dental provider; or
    c. Indian Health Service or Tribal 638 Program We will be the primary plan for any covered benefits payable by the Indian Health Service or 638 program unless otherwise prescribed by law.
2. *Non-Coordination of Benefits Plan Rule* If the other dental plan does not coordinate benefits, then the other dental plan will be the primary plan. This Plan will be the secondary plan.
3. *Hospital, Surgical, Medical, or Other Coverage Rule* Any medical, surgical, hospital, prescription drug plan, motor vehicle (including no-fault policies), or homeowner's insurance that provides dental-related benefits such as dental treatment due to accidental injuries, surgical extraction of impacted wisdom teeth, oral surgery, or the administration of general anesthesia will be the primary plan. This Plan will be the secondary plan.
4. *Employee/Dependent Rule* If both dental plans coordinate benefits, then:
    a. the dental plan that covers you or your Enrolled Dependent as an Employee or Subscriber will be the primary plan; and
    b. the dental plan that covers you or your Enrolled Dependent as a Dependent (or beneficiary under ERISA) will be the secondary plan unless both dental plans agree that COBRA or State continuation of coverage will be the secondary plan when the person who elects COBRA is covered by another dental plan as a Dependent.

5. *Dependent Children Covered Under Multiple Plans* Unless a parent is decreed by a court of law to have primary responsibility for dental coverage, the dental plan covering a dependent child shall determine the order of payment as follows:

    a. For a dependent child whose parents are married or are living together (whether or not they have ever been married):

        i. The dental plan of the parent whose birth date falls earlier in the calendar year is the primary plan; or

        ii. If both parents have the same birth date, the dental plan that has covered the parent the longest is the primary plan.

    b. For a dependent child whose parents are divorced, separated, or not living together (whether or not they have ever been married):

        i. If a court decree states that one parent is responsible for the dependent child's health care expenses or coverage and the plan of that parent has actual knowledge of those terms, then that dental plan is the primary plan. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, then that parent's spouse's dental plan is the primary plan. This will not apply for any plan year during which benefits are paid or provided before the plan has actual knowledge of the court decree provision;

        ii. If a court decree states that both parents are responsible for a dependent child's health care expenses or coverage, then provision of Subsection (a) of this Section 5 will determine the order of payment for covered benefits;

        iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of a dependent child, then provisions of Subsection (a) of this Section 5 shall determine the order of payment of covered benefits; or

        iv. If there is no court decree allocating responsibility for a dependent child's health care expenses or coverage, the order of payment of covered benefits are as follows:

            (1) The plan covering the custodial parent;

            (2) The plan covering the custodial parent's spouse;

            (3) The plan covering the non-custodial parent; and then

            (4) The plan covering the non-custodial parent's spouse.

    c. For a dependent child covered under multiple dental plans of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable under Subsections (a) or (b) of this Section 5, as if those individuals were parents of the dependent child.

    d. This Section 5 follows the Coordination of Benefits Model Law adopted by

the National Association of Insurance Commissioners ("NAIC"). It is not intended to violate any applicable federal or state law. If a situation arises that presents a risk of unlawful discrimination of a legally protected status, then we will find a solution that complies with applicable federal and state law.

6. *Laid-Off or Retired Rule* The dental plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee will be the primary plan. This Plan will be secondary.
7. *COBRA Coverage or State Law Rule* The dental plan that is provided under a right of continuation under COBRA or a similar State law will be the secondary plan, even if the individual enrolled in another dental plan as a Dependent. If the two dental plans do not agree on this order of coordinated covered benefits, then this Rule will be ignored. Also, this Rule will not apply if one of the Rules above applies, except as otherwise provided by law.
8. *Longer Length of Coverage Rule* The dental plan that has covered you for the longer period of time will be the primary plan.
9. *Sharing Coverage Rule* If none of the Rules above determines the primary plan, then the covered benefits can be shared equally between the parties. Again, this Plan shall not pay more than it would have paid had it been the primary plan.

E. Recovering Dental Expenses from Others

If we pay more than we should under this Coordination of Benefits Section, we may recover the excess from one or more of the persons we paid or for whom we have paid or any other person or entity that may be responsible for the covered benefits provided to you or your Enrolled Dependent as follows.

1. If you received Covered Services under this Plan for the treatment of injuries resulting from the act or omission of any other person, firm, operation, or entity, we will be subrogated to your rights or the personal representative of a deceased Enrolled Person or to the extent of all such payments made by us for such Covered Services. If we have paid for Covered Services, you must repay us from amounts recovered for all such payments made by us in any lawsuit, settlement, or by any other means. This applies to monies you may have received or will receive from any third party or insurer, or from any uninsured or underinsured motorist insurance benefits, as well as from any other person, organization, or entity.
2. Our right of subrogation includes but is not limited to the right to be repaid when an Enrolled Person recovers money for a personal injury sustained in an auto accident. This subrogation right applies whether an Enrolled Person recovers directly from the wrongdoer or from the wrongdoer's insurer or from your uninsured motorist insurance coverage. Enrolled Persons agree to sign and deliver to us such documents and papers as may be necessary to protect our right of subrogation. Enrolled Persons also agree to keep us advised of any claims or lawsuits made against any person, firm, or entity responsible for any injuries for which we have paid benefits, or any claim or lawsuit against any insurance company, or uninsured or underinsured motorist insurance carrier.
3. Settlement of a legal claim or controversy without prior notice to us violates

this Plan. If an Enrolled Person fails to cooperate with us or take any other action (through agents or otherwise) that interferes with the exercise of our subrogation right, we may have and hereby expressly reserve, all legal remedies available to us.

When we incur reasonable collection costs and legal expenses to recover amounts that benefit both an Enrolled Person and us, we will, upon request by you or your attorney, share such collection costs and legal expenses in a fair and equitable manner, only if we received appropriate documentation of such collection costs or legal expenses.

VI. Questions, Appeals, and Grievances

If you have any question about any action taken by Delta Dental of New Mexico with respect to the Plan, coverage, or a Claim, never hesitate to contact our Customer Services Team toll free at **(877) 395-9420** or **(505) 855-7111** Monday-Friday from 8 a.m.-4:30 p.m. MST. or by email at **customerservice@deltadentalnm.com**. Most of the time, we can answer your questions, provide information, address your issues, or correct errors quickly.

If you remain dissatisfied with a determination that we have made on a Claim that results in any denial, reduction, or termination of a benefit, or failure to make payment, in whole or in part, you may request a formal review and appeal. Claims determinations resulting in any denial, reduction, or termination of a benefit, or failure to make payment, in whole or in part, by us falls into two categories: an "Adverse Determination" or "Administrative Decision". The categorization determines your appeal rights by assuring that the right decision is made under your coverage and applicable law.

A. Adverse Determination Appeals

What is an "Adverse Determination"?

An Adverse Determination is any of the following:

1. Any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time);
2. A denial, reduction, or termination of, or a failure to make full or partial payment for a Benefit including any denial, reduction, termination, or failure to make payments that is based on a determination of an Enrolled Person's eligibility to participate in Plan;
3. A denial, reduction, or termination of, or a failure to make full or partial payment for a Benefit resulting from the application of any Utilization Review; or
4. Failure to cover a Service for which Benefits are otherwise provided because it is determined to be not Medically Necessary and appropriate.

What are examples of Adverse Determinations?

- We do not approve a Service requested by you or your Dental Provider.
- We do not pay for a Service that you have received.
- We do not authorize a Service or pay for a Claim because we say that it is

not Medically Necessary and appropriate.

- We do not authorize a Service or pay a Claim because we say that it is not covered.
- We do not timely notify you after receiving your request whether we will authorize the requested Service.
- We deny a Prior Authorization.

Are Adverse Determinations reviewed by Dental Consultants?

Yes. All Adverse Determinations are automatically reviewed by a Dental Consultant(s) who are dental professionals with appropriate qualifications and expertise.

What can you do if you don't agree with an Adverse Determination?

If you do not agree with an Adverse Determination made by the Dental Consultant(s), you may request a second-level Internal Panel Review.

Your decision to request an Internal Panel Review is voluntary and will not impact your right to any other Benefits under this your Plan. You will not be subject to any retaliatory action by us for any reason related to your grievance.

How much time do you have to request an Internal Panel Review?

You must make your request for an Internal Panel Review within **180 days** after you receive the notice of the Adverse Determination.

How do you request an Internal Panel Review?

You can request an Internal Panel Review either in writing or by phone. You must explain the reasons why you do not agree with the Adverse Determination and provide any support information or documents. You should also tell us how you would like the matter to be resolved.

You may send your request for an Internal Panel Review as follows:

By Mail:

Delta Dental Plan of New Mexico
Attn: Customer Services - Appeals & Grievances
100 Sun Avenue NE, Suite 400
Albuquerque, NM 87109

By Email:

customerservice@deltadentalnm.com

By Phone:**

Toll-Free at **(877) 395-9420** or locally at (**505) 855-7111**
Monday-Friday from 8 a.m.-4:30 p.m. MST.
Automated system is available 24/7.
** **Note**: if you submit your request by phone, our Customer Services Representative will assist you in preparing your request and you will need to confirm your request in writing to ensure that we accurately capture your grievance.

Can you authorize you Dental Provider or another person to be your representative?

Yes. You may authorize your dental provider or a representative, at your expense, to act for you in the Internal Panel Review process.

Your appointment of an authorized representative must be in writing and signed, so that we may prevent the unauthorized disclosure of protected information about you as required by law. You may download a form to designate an authorized representative from our website at **deltadentalnm.com** or request a form from the Customer Services Department by calling us toll-free at **1-877-395-9420** or **(505) 855-7111** Monday-Friday from 8 a.m.-4:30 p.m. MST. or by email at **customerservice@deltadentalnm.com,** or writing to **100 Sun Avenue NE, Suite 400, Albuquerque, NM 87109**.

Note that Delta Dental of New Mexico will not be charged any fees or costs incurred by you as part of the internal or external appeals process. If you arrange to be represented by an attorney or your witnesses require a fee, you will need to pay those fees.

What will happen after I submit my request for an Internal Panel Review?

We will acknowledge receipt of your request within **2 business days** for standard reviews. For expedited reviews, we will acknowledge by phone or email.

We will also provide you with an information packet that includes:

- Contact information for the Customer Service Representative who can assist you throughout the Internal Panel Review process;
- General information about your rights, the process, schedule, links, forms, and other information;
- Date and time of the Internal Panel Review meeting (if available) and information on how you may participate;
- How you may reasonably access or obtain copies of all information or rationale, considered, relied upon, or generated for the Internal Panel Review;
- How you may present or submit comments, documents, records, and other materials relating to your appeal;
- How you may request additional time so that you have a reasonable opportunity to prepare your response or participate; and
- If we will be represented by an attorney.

When will an Internal Review Panel be scheduled and how long will the process take?

When we receive your request, we will set up an Internal Review Panel of insurance and/or qualified dental care professionals, as appropriate, to review the Adverse Determination. We will inform you on the date and time of the Internal Panel Review meeting and information on how you may participate

Internal Panel Reviews will be completed within the following timeframes:

- Standard Internal Reviews

  Within **30 days** of receiving your appeal request for a pre-service Claim and within **60 days** of receiving your appeal request for a post-service Claim.

- Expedited Internal Reviews

  Within **72 hours** of receiving your appeal request. Expedited internal reviews involve urgent care situations based upon your medical condition.

- You may request or we may mutually agree on additional time so that you have a reasonable opportunity to prepare your response or participate, or we can assure that the process serves your best interests.
- If we do not adhere to these timeframes, then you may request an external review by the New Mexico Office of the Superintendent of Insurance ("OSI"). OSI contact information is provided below.

What will happen after the Internal Review Panel meets?

You and your Dental Provider will be notified of the Internal Panel Review decision ("Notice of Decision") within **5 business days** unless earlier notice is required under expedited review.

The Notice of Decision will provide you with an explanation of the decision, the basis for the decision, and the authority and evidence relied upon in making the decision.

If the Adverse Determination is upheld in whole or in part, the Notice of Decision will provide you information about the individuals on the Internal Review Panel, a statement of the Internal Review Panel's understanding of the nature of the appeal and pertinent facts, and a clear and complete explanation of the decision, the basis for the decision, and the authority and evidence relied upon in making the decision.

What can you do if you don't agree with the Internal Review Panel's decision?

The Notice of Decision will also explain that if you remain dissatisfied, you may file an external review request with the OSI within **4 months**. If the Adverse Determination involves an urgent care situation, you may immediately request an expedited external review with the OSI. The Notice of Decision will describe the process and necessary forms for you to request an external review with the OSI.

B. Administrative Decision Appeals

What is an "Administrative Decision"?

An **Administrative Decision** is any decision that we make about any aspect of the Plan other than an Adverse Determination such as:

1. Administrative practices of Delta Dental of New Mexico that affect the availability, delivery, or quality of Services;
2. Claims payment, handling, or reimbursement for Services, including but not limited to complaints concerning a Deductible, Copay or Coinsurance; and

3. Termination of coverage.

What are examples of Administrative Decisions?

- You disagree with our decision as to the amount of charges.
- You disagree with how we coordinate benefits when you have other dental coverage.
- You disagree with how we have applied your Claims or Services to a Deductible.
- You disagree with the amount of a Copayment or Coinsurance you paid.
- You disagree with our decision to issue or not issue a Plan to you.
- You believe we have violated the New Mexico Insurance Code.

What can you do if you don't agree with an Administrative Decision?

If you do not agree with an Administrative Decision, you may request an internal review. Your decision to request an internal review of an Administrative Decision is voluntary and will not impact your right to any other Benefits under the Plan. You will not be subject to any retaliatory action by us for any reason related to your grievance.

How much time do you have to request an internal review?

You will have **180 days** from the date of the Administrative Decision to ask for an internal review.

How do you request an internal review?

You can request an internal review of an Administrative Decision from us either in writing or by phone. You must let us know the reasons why you do not agree with the Administrative Decision and provide supporting information or documents. You should also tell us how you would like the matter to be resolved.

You may send your request for any level of internal review of an Administrative Decision to us:

By Mail

Delta Dental Plan of New Mexico
Attn: Customer Services - Appeals & Grievances
100 Sun Avenue NE, Suite 400
Albuquerque, NM 87109

By Email

customerservice@deltadentalnm.com

By Phone**

Toll-Free at **(877) 395-9420** or locally at **(505) 855-7111** Monday-Friday from 8 a.m.-4:30 p.m. MST. Automated system is available 24/7.

****Note**: if you submit your request by phone, our Customer Services Representative will assist you in preparing your request and you will

need to confirm your request in writing to ensure that we accurately capture your grievance.

Can you authorize your dental provider or another person to be your representative?

Yes. You may authorize your Dental Provider or a representative, at your expense, to act for you in the internal review process.

Your appointment of an authorized representative must be in writing and signed, so that we may prevent the unauthorized disclosure of protected information about you as required by law. You may download a form to designate an authorized representative from our website at **deltadentalnm.com** or request a form from the Customer Services Department by calling us toll-free at **(877) 395-9420** or **(505) 855-7111** Monday-Friday from 8 a.m.-4:30 p.m. MST. or by email at **customerservice@deltadentalnm.com**, or writing to **100 Sun Avenue NE, Suite 400, Albuquerque, NM 87109**.

Note that Delta Dental of New Mexico will not be charged any fees or costs incurred by you as part of the internal or external appeals process. If you arrange to be represented by an attorney or your witnesses require a fee, you will need to pay those fees.

What will happen after you submit your request for an internal review?

We will notify you within **2 business days** after receiving your request. We will provide you with contact information for the Customer Service Representative who can assist you throughout the process. We will also provide you with general information about the process and how you can submit relevant supporting information that you wish to be considered for the review.

How long will it take to complete the internal review?

The initial review of the Administrative Decision will be completed promptly. We will mail or email you a decision within **30 days** after receipt of your request.

What can you do if you don't agree with the outcome of the internal review?

If you remain dissatisfied, you will have **20 days** to request a Second-Level Internal Review.

What will happen after you submit a request for a Second-Level Internal Review?

When we receive your request, we will set up an Internal Review Committee of two or more of our representatives who were not involved in either the initial decision or the initial internal review.

What is the process for the Internal Committee Review?

We will notify you at least **3 days** before the Internal Review Committee meets so that you may provide information and/or participate. If you cannot participate, you may request up to a 30-day postponement. The Internal Review Committee will meet and decide within 15 days after we receive your request. The Internal Review Committee will mail its decision to you within 7 days after the meeting.

What can you do if you don't agree with the Internal Committee Review?

If you remain dissatisfied, you may request an external review of the Administrative Decision with the OSI within 20 days after you receive the Internal Review Committee's decision.

C. Office of Superintendent of Insurance or OSI

You may submit an external review request with or obtain information and assistance from the New Mexico Office of the Superintendent of Insurance ("OSI") as follows:

New Mexico Office of Superintendent of Insurance
Attn: Consumer Assistance Bureau
1120 Paseo de Peralta (PO Box 1689)
Santa Fe, NM 87501 (87504-1689)
Phone: 1-855-4-ASK-OSI (1-855-427-5674)
www.osi.state.nm.us/pages/bureaus/consumer/resources/consumer-assistance

VII. Termination of Coverage

A. When Coverage for an Enrolled Person Ends

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

B. When Payment for Claims Ends

If an Enrolled Person loses coverage, Delta Dental of New Mexico will only pay claims for Covered Services incurred prior to the loss of coverage. To be considered for payment, claims must be submitted to Delta Dental of New Mexico in writing within 12 months after the services have been provided and for

which Benefits are payable and will only be paid provided the Group's Administrative Services Agreement has not been terminated for cause.

C. Termination of the Group's Administrative Services Agreement with Delta Dental of New Mexico

In the event the Administrative Services Agreement between the Group and Delta Dental of New Mexico is canceled for any reason, including non-payment of Delta Dental of New Mexico's Administrative Fees or the Group's failure to fund claims on a timely basis, Delta Dental of New Mexico will discontinue providing administrative and claims processing services and access to the Delta Dental Network(s) on the date concurrent with the termination of the Administrative Services Agreement.

VIII. Continuation of Coverage

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

IX. ERISA

This Group dental Plan may be subject to the *Employee Retirement Income Security Act of 1974* ("ERISA"). This federal law provides for certain rights and protections. When applicable, the Group is responsible for providing Enrolled Persons notification of ERISA rights.

X. Notice of Privacy Practices

This section describes how Delta Dental of New Mexico protects the medical information of Enrolled Persons. DDNM understands that medical and health information is private and is committed to protecting the confidentiality and security of that information.

Delta Dental is required to provide this notice by law, specifically, the *Health Insurance Portability and Accountability Act of 1996 (*HIPAA). Delta Dental of New Mexico must:

- make certain to maintain the privacy of each Enrolled Person's protected health information;
- provide this notice of our legal duties and privacy practices with respect to protected health information;
- follow the terms of the notice that is currently in effect; and
- describe an Enrolled Person's rights with respect to protected health information and how Enrollees can exercise those rights.

This notice was effective April 14, 2003, and will remain in effect until amended.

Protected health information is information that may identify an Enrolled Person and relate to the past, present, or future health, treatment, or payment for health care services for that Enrollee. This notice applies to all of the medical records maintained by Delta Dental of New Mexico. An individual's Provider may have different policies or notices regarding the Provider's use and disclosure of medical information created in the Provider's office.

Delta Dental of New Mexico safeguards protected health information from inappropriate use or disclosure. DDNM employees, and those of companies that help Delta Dental of New Mexico service the dental Plan, are required to comply with DDNM requirements that protect the confidentiality of protected health information. Delta Dental of New Mexico will not disclose protected health information to any other company or person for their use in marketing their products to any individual without the expressed permission of that individual. However, as described in this notice, Delta Dental of New Mexico will use and disclose protected health information about an Enrolled Person for business purposes to administer the dental Plan and when required or authorized by law.

For answers to questions about this notice, contact:

Delta Dental of New Mexico
Attn: Legal-Compliance Department
100 Sun Avenue NE, Ste. 400
Albuquerque, NM 87109
toll free **(877) 395-9420** or locally at **(505) 525-9017**
compliance@deltadentalnm.com or HIPAAprivacy@deltadentalnm.com

The Privacy Notice is available on DDNM website at **www.deltadentalnm.com**

How Delta Dental of New Mexico May Use and Disclose Protected Health Information

The following categories describe different ways that Delta Dental of New Mexico is permitted to use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways Delta Dental of New Mexico is permitted to use and disclose information will fall within one of the categories.

1. **Payment:** Delta Dental of New Mexico may use and disclose protected health information to determine eligibility for Plan Benefits, to make Benefit payments for the treatment and services received from Providers, to determine Benefit responsibility under this Plan, to issue premium billings, and to coordinate Plan coverage. For example, the medical information contained on claims may be used to reimburse Providers for their services. Delta Dental of New Mexico may tell an Enrolled Person's Provider about dental history to determine whether this Plan will cover treatment. Delta Dental of New Mexico may also disclose protected health information to other insurance carriers and organizations to coordinate Benefit payments with respect to a particular claim.
2. **Health Care Operations:** Delta Dental of New Mexico may use and disclose protected health information as necessary for company operations. For example, Delta Dental of New Mexico may use medical information in connection with: providing customer service, evaluating a claim, quality

assurance, clinical review, and processing transactions requested by an Enrolled Person. Delta Dental of New Mexico may also disclose protected health information to Delta Dental of New Mexico affiliates, and to business associates outside of Delta Dental of New Mexico, if those affiliates or associates need to receive protected health information to provide a service to Delta Dental of New Mexico and will agree to abide by specific rules relating to the protection of protected health information. Examples of business associates are data processing companies, insurance agents, attorneys, auditors, or companies that furnish administrative support or services.

3. **Health-Related Benefits or Services:** Delta Dental of New Mexico may use protected health information to provide an Enrolled Person with information about Benefits available under the dental Plan.

4. **Incidental Disclosures:** Certain incidental disclosures of protected health information occur as a byproduct of lawful and permitted use and disclosure of protected health information. These incidental disclosures are permitted if Delta Dental of New Mexico applies reasonable safeguards related to protected health information.

5. **Others Involved in an Enrolled Person's Health Care:** Unless an Enrolled Person objects, Delta Dental of New Mexico may disclose protected health information to a dependent of the Enrolled Person's family, a relative, or any other person specifically identified, that directly relates to that person's involvement in the Enrolled Person's health care or payment for health care. If the Enrolled Person is unable to agree or object to such a disclosure, Delta Dental of New Mexico may disclose such information as necessary in an emergency or if Delta Dental of New Mexico determines that it is in the best interest of the Enrolled Person based on professional judgment.

6. **As Authorized by an Enrolled Person:** Other uses and disclosures of protected health information not covered by this notice and permitted by the laws that apply to Delta Dental of New Mexico will be made only with an Enrolled Person's written authorization or that of a legal representative. An Enrolled Person may authorize Delta Dental to use protected health information or disclose it to another person for a designated purpose. Such an authorization shall be valid for a specified length of time, not to exceed twenty-four (24) months. An Enrolled Person may withdraw the authorization in writing at any time, except to the extent that DDNM has taken action relying on the prior authorization, i.e., DDNM cannot take back disclosures already made with authorization.

7. **Authorized by Law for Public Benefit:** Delta Dental of New Mexico may use or disclose protected health information as authorized by law for the following purposes deemed to be in the public interest:

    a. as required by law;

    b. to avert a serious threat to health or safety;

    c. to report to federal, state, or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow

such entities to carry out their responsibilities in specific disaster situations;

d. for public health activities including reporting births and deaths, victims of abuse or neglect, reaction to medications or problems with products, and to prevent or control disease, injury, or disability;

e. to a coroner, medical examiner, or funeral director to assist in identifying a deceased individual or to determine the cause of death. Delta Dental of New Mexico may also release protected health information for organ donation purposes;

f. in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons, or similar process;

g. to federal officials for intelligence, counterintelligence, and other national security activities authorized by law;

h. as authorized to comply with Workers' Compensation laws and other similar legally established programs;

i. to a correctional institution if an Enrolled Person is an inmate at that correctional institution or law enforcement official if an Enrolled Person is under the custody of that law enforcement official;

j. in response to a court or administrative order if the Enrollee or the Enrollee's estate is involved in a lawsuit or a dispute. Delta Dental of New Mexico may also disclose protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell the Enrollee about the request or to obtain an order protecting the protected health information requested;

k. to any government agency or regulator with whom the Enrolled Person has filed a complaint or as part of a regulatory agency examination.

Individual Rights Regarding Protected Health Information

The following rights concerning protected health information apply under HIPAA.

An Enrolled Person may contact Delta Dental of New Mexico at the location listed in this notice to submit a request or for an explanation on how to submit a request, obtain forms, or get other additional information.

1. **Right to Inspect and Copy Protected Health Information:** In most cases, an Enrolled Person has the right to inspect and obtain a copy of his or her protected health information maintained by Delta Dental of New Mexico. To inspect and copy protected health information, an Enrollee must submit a request in writing. If a copy of protected health information is requested, a fee may be charged for the costs of copying, mailing, or other supplies associated with the request. However, certain types of protected health information will not be made available for inspection and copying. This includes protected health information collected by Delta Dental of New Mexico in connection with, or in reasonable anticipation of, any claim or legal proceeding. In very limited circumstances Delta Dental of New Mexico may

deny a request to inspect and obtain a copy of protected health information. A review of that denial may be requested. An individual chosen by Delta Dental of New Mexico who was not involved in the original decision to deny the request will conduct the review. Delta Dental of New Mexico will comply with the outcome of that review.

2. **Right to Amend Protected Health Information:** If an Enrolled Person believes his or her protected health information is incorrect or that an important part of it is missing, the Enrollee has the right to ask Delta Dental of New Mexico to amend the protected health information while it is kept by or for Delta Dental of New Mexico. This request, and the reason for the request, must be submitted in writing. Delta Dental of New Mexico may deny the request if it is not in writing or does not include a reason that supports the request. In addition, Delta Dental of New Mexico may deny the request if it is to amend protected health information that (a) is accurate and complete; (b) was not created by Delta Dental of New Mexico, unless the person or entity that created the information is no longer available to make the amendment; (c) is not part of the protected health information kept by or for Delta Dental of New Mexico; or (d) is not part of the protected health information which would be permitted to inspect and copy.
3. **Right to a List of Disclosures:** An Enrolled Person has the right to request a list of the disclosures Delta Dental of New Mexico has made of his or her protected health information. This list will not include disclosures made (a) for treatment, payment, or health care operations; (b) for purposes of national security, law enforcement, or to corrections personnel; (c) made pursuant to person's authorization; or (d) made directly to the Enrolled Person. The request must be submitted in writing and state the time period applicable to the list of disclosures. The time period may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form the list is requested (for example, on paper or electronically). The first list requested within a twelve (12) month period will be free. Delta Dental of New Mexico may charge the individual making the request for responding to additional requests. Delta Dental of New Mexico will identify the cost involved and the individual making the request may choose to withdraw or modify the request before any costs are incurred.
4. **Right to Request Restriction or Limitation on Protected Health Information:** An Enrolled Person has the right to request a restriction or limitation on protected health information used or disclosed for treatment, payment, or health care operations, or request disclosure to someone who may be involved in the care or payment of his or her care, such as a family member. To request a restriction, an Enrollee must send the request in writing and tell Delta Dental of New Mexico (a) what information should be limited; (b) whether the limitation would apply to Delta Dental of New Mexico use, disclosure, or both; and (c) to whom the limits would apply (for example, disclosures to a Spouse, Domestic Partner, or parent). While Delta Dental of New Mexico will consider the request, Delta Dental of New Mexico is not required to agree to it. Delta Dental of New Mexico will not agree to restrictions on protected health information uses or disclosures that are

legally required, or which are necessary to administer Delta Dental of New Mexico business.

5. **Right to Request Confidential Communications:** An Enrolled Person has the right to request that Delta Dental of New Mexico communicate protected health information in a certain way or at a certain location if the Enrolled Person informs Delta Dental of New Mexico that communication in another manner may endanger the Enrolled Person. For example, the Enrolled Person may request that Delta Dental of New Mexico only make contact at work or by mail. To request confidential communications, a request must be sent in writing, which specifies how or where you wish to be contacted. Delta Dental of New Mexico will accommodate all reasonable requests.
6. **Right to Receive a Copy of the Notice:** An Enrolled Person may request a copy of our notice at any time by contacting the Privacy Office or by using the Web site, **deltadentalnm.com**. If this notice is obtained via the Web site or by electronic mail, the Enrolled Person is also entitled to request a paper copy.
7. **Right to File a Complaint:** If an Enrolled Person believes his or her privacy rights have been violated, he or she may file a complaint with Delta Dental of New Mexico. All complaints must be submitted in writing. There will not be a penalty for filing a complaint. For answers to questions about how to file a complaint, please contact Delta Dental of New Mexico at **(877) 395-9420** or locally at **(505) 855-7111** Monday-Friday from 8 a.m.-4:30 p.m. MST. or by email at **compliance@deltadentalnm.com** or **HIPAAprivacy@deltadentalnm.com**.

Additional Information

Changes to this Notice: Delta Dental of New Mexico reserves the right to change the terms of this notice at any time. Delta Dental of New Mexico reserves the right to make the revised or changed notice effective for protected health information previously received as well as any protected health information received in the future. The effective date of this notice and any revised or changed notice will be included in the notice. Enrolled Persons will receive a copy of any revised notice from Delta Dental of New Mexico by mail or by e-mail, but only if e-mail delivery is offered by Delta Dental of New Mexico and the Enrolled Person agrees to such delivery.

Further Information: For additional information regarding the Delta Dental of New Mexico HIPAA Medical Information Privacy Policy or general Delta Dental of New Mexico privacy policies, please contact Delta Dental of New Mexico at:

Delta Dental of New Mexico
Attn: Compliance Department
100 Sun Avenue NE, Ste. 400
Albuquerque, NM 87109
toll free **(877) 395-9420** or locally at **(505) 525-9017**
compliance@deltadentalnm.com

XI. General Conditions

A. Non-Assignment and Payment of Covered Services

Payments for Covered Services are for the personal benefit of Enrolled Persons. Payments for Covered Services or Benefits cannot be assigned or transferred. An Enrolled Person may only authorize the direct payment of Covered Services to a Non-Participating Provider as required by this Plan and permitted by law.

B. Reimbursement

When Delta Dental of New Mexico pays benefits under the Plan and it is determined that negligent third party is liable for the same expenses, Delta Dental of New Mexico has the right to receive reimbursement from monies payable from the negligent third party equal to the amount that we have paid for such services. Enrolled Persons hereby agree to reimburse us first, from the monies recovered from a negligent third party as a result of a judgment against, settlement with, or otherwise paid by the third party as a result of a judgment against, settlement with, or otherwise paid by the third party. Enrolled Dependent Persons agree to take action against the third party, furnish all information, and provide assistance to us regarding the action taken, and execute and deliver all documents and information necessary for us to enforce our rights of reimbursement. This provision applies whether or not the third party admits liability. *See also,* [Section VII(E) and Section VIII(G)].

C. Right of Recovery Due to Fraud

If Delta Dental of New Mexico pays: (1) Benefits for eligible dental expenses incurred by an Enrolled Person that were sought or received under fraudulent, false, or misleading pretenses or circumstances; (2) a Claim that contains false or misrepresented information; or (3) pays a Claim that is determined to be fraudulent due to the acts of an Enrolled Person, then Delta Dental of New Mexico may recover that payment from Enrolled Persons. Delta Dental of New Mexico may recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to an Enrolled Person. We will provide an explanation of the payment recovery at the time the deduction is made.

D. Right to Recover Erroneous Payments

If Delta Dental of New Mexico pays Benefits for eligible dental expenses incurred by an Enrolled Person and it is found that the payment was more than it should have been, or was made in error, we have the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, we may deduct any refund due from any future benefit payment.

E. Obtaining and Releasing Information

While covered by Delta Dental of New Mexico, Enrolled Persons agree to provide us with any information that we need to process Claims and administer Benefits under this Plan. This includes allowing Delta Dental of New Mexico to have access to dental records of an Enrolled Person. If an Enrolled Person files a Claim, the Enrolled Person authorizes the Dental Provider, insurance carrier, or other entity

to furnish us all information and records or copies of records about diagnosis, treatment, or care. In filing a Claim, an Enrolled Person will be considered to have waived any and all requirements forbidding the disclosure of this information and records.

F. Provider-Patient Relationship

An Enrolled Person may choose any Dental Provider. Delta Dental of New Mexico does not furnish Services, but only makes payment for Covered Services incurred by Enrolled Persons. Delta Dental of New Mexico is not liable for any advice, act, or omission of a Dental Provider or any resulting liability. We also do not have any responsibility for a Dental Provider's refusal to provide Services to an Enrolled Person.

G. Actions Against Delta Dental of New Mexico

No lawsuit or action in law or equity arising out of or related to this Plan shall be brought by you or on your behalf against Delta Dental of New Mexico without first providing us 60 days' written notice of the legal claim and no such action shall be brought within 3 years after the legal claim first arose. Any person seeking to do so will be deemed to have waived the right to bring suit on such legal claim.

H. Governing Law

This Plan shall be governed by and interpreted under the laws of the State of New Mexico.

I. Legally Mandated Benefits

If any applicable law requires broader coverage or more favorable treatment for an Enrolled Person than is provided by this Plan, that law shall control over the language of this EOC and the Summary of Benefits.

J. Amendments

This Plan may be amended or changed at any time by agreement between the Employer and Delta Dental of New Mexico. This EOC may only be amended when authorized by an officer of Delta Dental of New Mexico. We will give the Employer Group at least 30 days prior written notice of an amendment to this EOC or new coverage. No employee of Delta Dental of New Mexico may change this EOC by giving incomplete or incorrect information, or by contradicting the terms of this EOC. Any such situation will not prevent us from administering this Plan in accordance with its terms and conditions. No insurance producer may change this Plan or waive any of its provisions.

K. Entire Contract and Changes

This EOC, including the Summary of Benefits, application, any endorsements and attachments, constitutes the entire contract between the parties hereto. No change in this Plan will be effective until approved by an executive officer of Delta Dental of New Mexico. This approval must be noted on or attached to this Plan. No insurance producer may change this Plan or waive any of its provisions.

XII. Definitions

Administrative Fee(s): The fees from the Group due to Delta Dental of New Mexico for Plan administration as prescribed by the Administrative Services Agreement.

Administrative Services Only Agreement or Administrative Services Agreement: The Administrative Services Agreement document, including any Declarations Page, the Dental Benefit Handbook[2], the Summary of Benefits, and, if applicable, successor agreements or renewals initially or thereafter issued or executed.

Allowed Amount: The Maximum Approved Fees either set by Delta Dental of New Mexico or contractually agreed upon with a Participating Provider for each dental service or procedure before application of Coinsurance and Deductible.

Balance Billing: a business practice adopted by a Provider to collect the difference between the Submitted Amount set by the Provider and the Allowed Amount of Delta Dental of New Mexico. Note that Participating Providers agree to accept the Approved Fee as payment in full and cannot Balance Bill an Enrolled Person for any difference.

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

Benefits: The maximum amount that Delta Dental of New Mexico will pay for covered dental services as described in Section III, "Benefits, Limitations, and Exclusions," and in the Summary of Benefits.

Coinsurance: The percentage of the Provider's approved fee due from the Enrolled Person to the Provider after Deductible requirements are met under the Plan.

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

Deductible: The amount an Enrolled Person or family must pay toward Covered Services before Delta Dental of New Mexico makes any payment for those Covered Services.

Delta Dental or Delta Dental Plan of New Mexico, Inc. or DDNM: a New Mexico non-profit corporation licensed to transact insurance and administrative services business as a non-profit health care plan.

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 or Summary Plan Description: This document. Delta Dental of New Mexico will provide Benefits as described in this Dental Benefit Handbook and the Summary of Plan Benefit. Any changes in this Dental Benefit Handbook will be based on changes to the Administrative Services Agreement between Delta Dental of New Mexico and your employer or organization.

[2] Also known as the Summary Plan Description or Evidence of Coverage.

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 Provider or Dentist: A means a person qualified and licensed under the laws of the State of New Mexico to practice dentistry or dental therapy, or dental hygienists or dental hygienists certified in collaborative practice and any service constituting the practice of dentistry under New Mexico law 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 of New Mexico, nor collectable from the Member by a Delta Dental 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 Benefits.

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

Eligible Employee: An employee who meets the conditions of employee eligibility outlined in Section I, "Eligibility and Enrollment," whether or not actually enrolled.

Enrolled Dependent: An Eligible Dependent whose completed enrollment information has been approved by the Group and received by Delta Dental. An Enrolled Dependent is considered a "Plan Participant" as defined in the Administrative Services Agreement.

Enrolled Employee: An Eligible Employee whose completed enrollment information has been approved by the Group and received by Delta Dental of New Mexico. An Enrolled Employee is considered a "Plan Participant" as defined in the Administrative Services Agreement.

Enrolled Person or Enrollee: An Enrolled Employee, Enrolled Dependent, COBRA-enrolled person, or other individual who meets the conditions of eligibility outlined in Section I, "Eligibility and Enrollment," and whose completed enrollment information has been approved by the Group and received by Delta Dental of New Mexico. An Enrolled Person or Enrollee is considered a "Plan Participant" as defined in the Administrative Services Agreement.

Experimental/Investigational: Any Service that is not recognized in accordance with generally accepted professional medical/dental standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services that require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the Services is rendered shall be considered Experimental or Investigational. Services that are not approved or recognized in accordance with accepted professional medical/dental standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients shall be considered Experimental or Investigational.

Group: The Group is considered the "Plan Sponsor" as defined in the Administrative Services Agreement.

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 Dental Provider for a Service, irrespective of the Dental 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. Delta Dental Providers agree not to charge Delta Dental Members more than the Maximum Approved Fee for a Covered Service. In all cases, Delta Dental of New Mexico will make the final determination regarding the Maximum Approved Fee for a Covered Service.

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

Medical Necessity or Medically Necessary: A proposed or provided Service for an Enrolled Person that meets all the following requirements:

1. Recommended by a Dental Provider practicing within the scope of their license and who has personally evaluated the Enrolled Person;
2. Essential to and provided for prevention, evaluation, diagnosis, or treatment of the Enrolled Person's dental condition, disease, or injury;
3. Consistent with the symptoms, findings, and diagnosis related to the Enrolled Person's dental condition, disease, or injury;
4. Clinically appropriate for diagnosis and treatment of the Enrolled Person's dental condition, disease, or injury in terms of type, frequency, extent, site, and duration of the intervention;
5. Considered to be an effective intervention for the Enrolled Person's dental condition, disease, or injury which can reasonably be expected to have beneficial health outcomes that outweigh potential harmful effects;
6. Performed in accordance with relevant credible scientific evidence and generally accepted professional standards of care; and
7. Required for reasons other than the convenience of the Enrolled Person or Dental Provider.

Note that Delta Dental of New Mexico may use Dental Consultants to determine or validate Medical Necessity and appropriateness.

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

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 Dental Providers may bill the patient the full submitted charge as well as any charges for Disallowed Services.

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

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

Participating Provider or Delta Dental Provider: A Dental Provider who has entered into and agreed to abide by the terms and conditions prescribed by a Delta Dental Participating Provider Agreement.

Pre-Treatment Estimate: A written estimate issued by Delta Dental of New Mexico 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 Benefits.

Processing Policies: Delta Dental of New Mexico's policies and guidelines used for Pre-Treatment Estimates and payment of claims. The Processing Policies may be amended from time to time by Delta Dental of New Mexico in its sole discretion.

Qualifying Event: Certain changes in the circumstance or life situation that may allow an eligible employee to change benefits outside of an annual open enrollment period. These events are defined by Section 125 of the federal Internal Revenue Code and include: marriage; divorce; legal separation or annulment; birth adoption, placement for adoption or appointment of legal guardianship of a Child; death of a Dependent; or the gain or loss of a Dependent's coverage.

Services: Dental services, supplies, devices, procedure, equipment, or treatment rendered by a Dental Provider considered to be safe, effective, and Medically Necessary and appropriate for the diagnosis or treatment of an existing dental condition. As provided in the Plan, Covered Services do not include Experimental or Investigational services, or elective Services. Delta Dental of New Mexico reserves the right to make the final decision as to whether Services are Experimental or Investigational Services, Elective Services, or Medically Necessary and appropriate 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: A Service 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 law.

Submitted Amount: The amount set by a Dental Provider for specific Services that is based upon the Provider's desired fee, taxes, overhead, margin, and other factors, and billed to Delta Dental as part of a claim. A Participating Provider cannot charge you or your Enrolled Dependents for the difference between this amount and the Maximum Approved Fee, which is known as "Balance Billing".

Subscriber: Means all people who are members or employees of the Group, are certified as being eligible by the Group, and are enrolled to receive Benefits under this Plan. A Subscriber is considered a "Primary Plan Participant" as defined in the Administrative Services Agreement.

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

Tele-Dental Service: A Dental Provider's use of electronic information, imaging, and communication technologies such as interactive audio, video, and data communications as well as store-and-forward technologies, to provide and support the delivery, diagnosis, consultation, treatment, transfer of dental data, and education for Services.

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

This Plan: The dental coverage established by the Group for eligible persons as set forth in the Administrative Services Agreement.

Utilization Review: A formal process designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy, or efficiency of Services. Utilization Review assists Delta Dental in making coverage determinations, control costs, and monitor quality of care. Utilization Review is also referred to as clinical review.

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