Group Dental Plan
Summary Plan Description

Dental Benefit Handbook

State of New Mexico
General Services Department
Risk Management Division

Dental Plan administered by Delta Dental

Welcome to the growing number of people who receive dental benefits under a Plan administered by Delta Dental.

This Summary Plan Description describes the provisions of your group dental plan ("Plan") established by the State of New Mexico General Services Department, Risk Management Division (GSD/RMD) for the exclusive benefit of eligible employees of the State of New Mexico and participating Local Public Bodies. GSD/RMD established the Plan as a self-insured dental plan for the purpose of providing dental benefits for covered participants.

GSD/RMD reserves the right to change or amend any or all provisions of this dental Plan and to terminate the Plan at any time. Any modification of the Plan will apply to all persons who are covered by the Plan at the time of such change, whether or not employed.

GSD/RMD has hired Delta Dental to process claims under the Plan. Delta Dental does not serve as an insurer, but merely as a claims processor. Claims for benefits are sent to Delta Dental, who processes the claims, then requests and receives funds from GSD/RMD to pay the claims, and then makes payment to dental service providers. Delta Dental also administers enrollment, customer service, and the provider network. While GSD/RMD and Delta Dental share responsibility for administering the Plan, GSD/RMD is ultimately responsible for providing dental plan benefits, not Delta Dental.

Please take time now to familiarize yourself with your dental benefits. If you have questions about your benefits, please call:

Delta Dental's Customer Service

(505) 855-7111

or

Toll free (877) 395-9420

Good oral health is an important part of good general health. Your Plan is designed to promote regular dental visits. We encourage you to take advantage of your Plan by calling a Delta Dental dentist today for an appointment.

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I. SUMMARY OF BENEFITS

Dental Plan Administered by

DELTA DENTAL

PPONEW MEXICO

SERVICES	In-Network	Out-of-Network
DIAGNOSTIC & PREVENTIVE SERVICES	**Plan Pays 100% You Pay: 0%**	**Plan Pays 100% You Pay: 0% ***
Oral Examinations - twice in a calendar year Routine or Periodontal Cleanings – twice in a calendar year Radiographic Images- Complete series/panoramic images - once every 5 years/Bitewing - twice in a calendar year Topical Fluoride Application- through age 18, twice in a calendar year Emergency Treatment - for relief of pain Sealants - through age 15, permanent molars only, 3 year limitation Space Maintainers - through age 18, five year limitation		
BASIC SERVICES	**Plan Pays 80% You Pay: 20%**	**Plan Pays 55% You Pay: 45% ***
Amalgam or composite resin fillings Stainless steel crowns - primary teeth only Extractions - non-surgical Oral Surgery—maxillofacial surgical procedures of the oral cavity, including surgical extractions Endodontics - pulp therapy and root canal filling Periodontics - non-surgical and surgical treatment of gum disease Repairs to crowns, implants, onlays, bridges, partial or complete dentures Adjustments to partial or complete dentures General Anesthesia - intravenous sedation and general anesthesia, when dentally necessary and administered by a licensed provider for a covered oral surgery procedure		
MAJOR SERVICES	**Plan Pays 60% You Pay: 40%**	**Plan Pays 35% You Pay: 65% ***
Onlays, Crowns and Cast Restorations - when teeth cannot be restored with amalgam or composite resin restorations Prosthodontics - procedures for construction of fixed bridges, partials or complete dentures Implants – specified services and related prosthodontics, subject to clinical review/approval		
ORTHODONTIC SERVICES Children up to 18th birthday	**Plan Pays 75% up to a $2000 lifetime maximum You Pay: 25% ***	
Adults, 18 and over	**Plan Pays 60% up to a $1,750 lifetime maximum You Pay: 40% ***	
CALENDAR YEAR DEDUCTIBLE (applies to Basic and Major Services)	**You Pay: $50 per enrolled person $150 aggregate per family**	
CALENDAR YEAR MAXIMUM (excludes expenses for Orthodontic Services)	**Plan Pays up to: $1750 per enrolled person**	

II. ELIGIBILITY AND ENROLLMENT

A. Who is Eligible?

1. Employee Eligibility

    - An eligible An eligible employee includes anyone hired as classified, Governor-exempt, probationary, temporary, term or hourly, if the employee works an average of at least 20 hours per week over the course of a pay period and whose length of employment, when hired, is for at least six months. Elected Officials, if part of the State or a participating LPB, are considered eligible and do not need to meet the work schedule of at least 20 hours per week. Independent contractors are not eligible under the State benefit plan.
    - Temporary employees whose original term of employment was to be less than six months, but it is later determined will be longer than 6 months, may be eligible for coverage if they are scheduled to work at least 20 hours per week. Employees will be eligible for benefits, as long as the employee has met the required eligibility waiting period, upon the offer of extended employment.
    - Dual coverage is not allowed. If both an employee and their spouse/domestic partner are eligible employees, they cannot enroll each other as a spouse/domestic partner, nor can they both cover their children.

2. Dependent Eligibility

    Dual coverage is not allowed. An eligible dependent cannot be covered by more than one employee participating in the Plan.

    - An eligible employee's lawful spouse may be enrolled as a dependent after presenting a marriage certificate or other documentation which establishes that the couple entered into a valid common-law marriage in another jurisdiction. Same sex marriage certificates from states that legally recognize same sex spouses (currently including NM) shall be treated as an employee & spouse.
    - An eligible employee's domestic partner may be enrolled as a dependent upon submission of executed Affidavits of Domestic Partnership.
    - An eligible employee's children and legal dependents under the age of twenty-six (26) may be enrolled as dependents upon submission of a birth certificate, legal adoption papers, and/or guardianship order.
    - Disabled legal dependents that are incapable of self support are eligible for dental coverage beyond age twenty-six (26). Evidence of legal guardianship and disability is required upon enrollment.
    - A court order directing that an employee and/or employee's dependent provide insurance for someone else does not require the State to grant eligibility. Individual coverage may need to be purchased separately.
    - If an employee's spouse has step-children from a previous marriage, and neither the employee nor spouse has adopted them or obtained legal guardianship, the step-children are not eligible for coverage.

3. When an employee is pressed into active military service, all benefits are provided by the federal government (including employees' dependents). Upon timely return from military duty per the rules set forth in Uniformed Services Employment and Reemployment Rights Act (USERRA), benefits for the employees and eligible dependents must be re-activated with the same coverages, with no waiting period.

B. Enrollment Requirements

1. Upon becoming eligible, employees and their eligible dependents must enroll to be covered under the plan. An enrollment form must be completed and submitted to your Human Resource Group Representative within 31 days of eligibility.
2. An enrolled employee may elect to enroll eligible dependents under the following conditions:
   - eligible dependents must be enrolled at the time the eligible employee becomes enrolled, within 31 days from the date they become dependents, within 31 days of loss of other dental coverage, or during an Open Enrollment period;
   - dependents may not be enrolled unless the eligible employee enrolls;
   - married eligible employees of the same group may enroll separately or together, but not both;
   - newly-born children may be enrolled within thirty-one days of birth or at Open Enrollment;
   - qualified domestic partners must be couples who are in an exclusive and committed relationship for mutual benefit, similar to a marriage relationship in the State of New Mexico. Domestic partners must share a common, primary residence for twelve (12) or more consecutive months, and must be jointly responsible for each other's common welfare, as well as shared financial obligations. Domestic partners must be at least 18 years of age, and may not be married; nor can they be a member of another domestic partnership; nor has either been so during the past 12 months. Domestic partners are also forbidden from being blood relations to a degree of closeness that would prevent them from being married in the State of New Mexico. A singed Affidavit of Domestic Partnership must be provided in order for a partner to be added as a dependent. Employees of Participating Local Public Bodies must verify with their Human Resource Group Representative as to the eligibility of domestic partners for your group.
   - children of domestic partners must be primarily dependent upon the enrolled employee or domestic partner for support and one or both of the domestic partners must be the biological parent of the child, adoptive parent of the child or the child has been placed in the domestic partners' household as part of an adoptive placement, legal guardianship, or court order, with the exclusion of foster children.
3. The Plan allows for an annual Open Enrollment period for all eligible employees. Open Enrollment is a period of time specified by GSD/RMD to allow eligible employees and/or their dependents to enroll in the plan or to cancel coverage under the plan for the renewed benefit period.
4. Newly eligible employees have an opportunity to enroll within 31 days of initial eligibility. Employees who waive coverage at the time of initial eligibility will **NOT** have an opportunity to enroll until the next Open Enrollment period, unless the employee experiences a qualifying event or change in family status.
5. You must notify your Human Resource Group Representative of any event causing a change in the status of an eligible dependent within thirty-one (31) days of the qualifying event. Qualifying events include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.
6. The Plan will not pay benefits for persons who are not enrolled.
7. Both the employee and the employer contribute to the premium cost of this Plan.

III. HOW THE PLAN WORKS

This section describes how your plan is designed, how you access your benefits and the effect of your dentist selection. If you have any questions regarding how your plan works, please call Delta Dental's Customer Service at (505) 855-7111 or toll free (877) 395-9420.

A. Your Dentist Selection

Your dental plan is based on a preferred provider program. You have the freedom to choose any dentist, but have lower out-of-pocket costs when selecting an In-Network dentist. Delta Dental does not require that you pre-select a dentist and does not guarantee that a particular dentist will be available. Each enrolled person in your family may choose a different dentist. As an enrolled person, your out-of-pocket expense will vary depending on whether your dentist participates in the PPONew Mexico network, another Delta Dental network or does not participate in any of our networks.

1. PPONew Mexico Dentists

You receive the highest level of benefit when you visit an In-Network dentist. In New Mexico, PPONew Mexico dentists qualify as In-Network dentists. PPONew Mexico dentists have agreed to accept the PPONew Mexico Schedule of Fees or their fee, whichever is lower, as payment in full and will not balance bill you above this amount. When you visit a PPONew Mexico dentist, you pay the In-Network patient copayment and deductible for covered services. You are also responsible for full payment for any non-covered services.

Outside New Mexico, Delta Dental PPO dentists qualify as In-Network dentists. Delta Dental PPO dentists rendering services outside the state of New Mexico have agreed to accept the Delta Dental PPO Schedule of Fees for the Delta Dental plan operating in the state where services are provided. You pay the In-Network patient copayment and deductible for covered services. You are also responsible for full payment for any non-covered services.

2. Other Delta Dental dentists

Other Delta Dental participating dentists who do not participate in PPONew Mexico are called Delta Dental Premier dentists and have agreed to accept the Maximum Approved Amount or their fee, whichever is lower, for all Delta Dental enrolled persons. When you visit a Delta Dental Premier dentist, the Plan will calculate benefits at the Out-of-Network benefit level. You are responsible for the difference between the Delta Dental Premier dentist's approved fee and the Plan's benefit payment which is based on PPONew Mexico Schedule of Fees. You are also responsible for full payment for any non-covered services.

3. Non-participating dentists

You may visit a dentist who does not participate in any of Delta Dental's networks and receive the Out-of-Network benefit. You are responsible for paying the difference between the non-participating dentist's billed fee and the Plan's benefit payment which is based on PPONew Mexico Schedule of Fees. You are also responsible for full payment for any non-covered services.

A listing of Participating Dentists will be provided. This list will be accurate as of the date printed on it, but the list of Participating Dentists changes frequently. To be sure the dentist of your choice is a Participating Dentist, you may call Delta Dental's Customer Service at (505) 855-7111 or toll free at (877) 395-9420, or use Delta Dental's online Find a Dentist tools in the Members area of deltadentalnm.com.

For dentists in New Mexico, select In-State then choose PPONew Mexico
For dentists outside New Mexico, select National Search then choose Delta Dental PPO

B. Accessing Your Benefits

To use your plan, follow these steps:

1. Read this Summary Plan Description carefully to become familiar with the benefits, the method of payment and the provisions of your Plan.

2. Make an appointment with your dentist and tell him or her that your dental benefits are administered by Delta Dental. If your dentist is not familiar with your Plan or has any questions regarding the Plan, their office may contact Delta Dental's Customer Service at (505) 855-7111 or toll free (877) 395-9420.

3. A claim needs to be filed with Delta Dental after receiving your dental treatment. All participating Delta Dental dentist offices will file the claim directly with Delta Dental on your behalf. If you visit a non-participating dentist, you are responsible for filing a claim with Delta Dental. Claims must be submitted to Delta Dental in writing within 12 months after the services have been provided and for which benefits are payable. Failure to submit the claim within such time shall not void or reduce any claim if it is shown not to have been reasonably possible to submit a claim within 12 months and that a claim was submitted as soon as reasonably possible. If Delta Dental does not respond within 15 days to a request to furnish a dental claim form, the requirements for claims submission shall be deemed to have been complied with upon the submission to Delta Dental.

4. If you visit a non-participating dentist outside of the United States it becomes your responsibility to obtain necessary documentation for the services provided. You must complete a claim form that includes completion of the "Patient Section." The dental office providing services must complete an itemization of services that includes tooth number if applicable, a description of each individual service, a date of service, a fee for each individual service and be signed by the dentist prior to submission to Delta Dental.

   If the services performed by a non-participating dentist outside the United States are for extractions, crowns, bridges, dentures, or partial dentures, a radiographic image of the area must be obtained prior to the service being considered for benefits. It is your responsibility to obtain necessary documentation for services provided. You are responsible for filing a claim with Delta Dental for the services you receive. Additionally, you are responsible for payment to the dentist at the time services are performed.

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

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

6. Within 30 days of receiving a valid claim, Delta Dental will send a Notification of Benefits which records Delta Dental's benefit determination, any payment made by the Plan and any amount owed by you. The Notification of Benefits will be mailed to the enrolled employee, or other appropriate beneficiary, and to the treating dentist if a Delta Dental participating dentist. This 30-day period for claim determination may be extended an additional 15 days due to matters beyond the control of Delta Dental by notifying you of the necessary extension prior to the expiration of the initial 30-day period.

   If a claim for benefits is reduced or denied, the Notification of Benefits will state the reason for the adverse determination. If you think Delta Dental incorrectly denied all or part of your claim, you may request a review by following the steps described in VII. Claim Appeal.

C. Your Out-of-Pocket Expenses

The Plan is designed for cost sharing between you and your employer for the services provided by a dentist.

1. Deductible

The Plan requires you to pay a portion of the initial expense toward covered services in each calendar year. You pay a $50 deductible each calendar year per enrolled person up to a maximum aggregate deductible of $150 per family.

The deductible does NOT apply to DIAGNOSTIC AND PREVENTIVE SERVICES or ORTHODONTIC SERVICES. Payments for services described under DIAGNOSTIC AND PREVENTIVE SERVICES or ORTHODONTIC SERVICES will not be credited toward the deductible.

2. Patient Copayment

The patient copayment is the portion of the covered amount that is paid to the dentist for covered services which is the enrolled person's responsibility. The amount of your patient copayment will vary depending on the level of coverage for the particular dental treatment and your selection of an In-Network dentist or an Out-of-Network dentist as described in Your Dentist Selection and the Summary of Benefits.

3. Maximum Benefit Amount

The Plan will pay up to a maximum of $1750 each calendar year for each enrolled person for covered services. Any amount for covered dental services that exceeds the maximum during the calendar year is your responsibility.

4. Orthodontic Maximum Benefit Amount

The Plan will pay up to a lifetime maximum of $2000 for children to the age of eighteen (18) and $1,750 for adults, age eighteen (18) and older. The orthodontic maximum benefit amount is determined by your age when orthodontic treatment is started. Any amount for ORTHODONTIC SERVICES that exceeds the lifetime maximum is your responsibility.

D. Pre-treatment Estimate of Benefits

As an optional service, you may request a pre-treatment estimate of benefits by Delta Dental if you wish to know in advance whether a recommended treatment is covered, how much the Plan will pay and what your financial obligation will be.

When your dentist recommends major services, we strongly advise that he or she submit a treatment plan to Delta Dental for a pre-treatment estimate of benefits on your behalf. A pre-treatment estimate is not required as a condition for payment of benefits by the Plan.

A pre-treatment estimate of benefits is subject to maximums, deductibles, eligibility and all other Plan provisions at the time services are performed.

E. Clinical Review

1. All claims are subject to review by a licensed dental consultant.
2. Delta Dental may require that an enrolled person be examined by a licensed dental consultant or an independent licensed dentist.
3. Delta Dental may obtain necessary information relating to an enrolled person from any dentist or hospital in which a dentist's care is provided, prior to approving a claim. Such information and records acquired by Delta Dental will be kept confidential.

F. To Whom Benefits Are Paid

1. Delta Dental will pay a participating dentist directly for services provided by that dentist. The enrolled person is responsible for paying the dentist directly for any non-covered services.
2. Delta Dental will pay the enrolled employee directly for services provided by a non-participating dentist practicing in New Mexico. The enrollee is responsible to make full payment to the non-participating dentist according to their office's billing practices. Delta Dental does not honor assignment of benefits to non-participating dentists in New Mexico.
3. Delta Dental will pay a non-participating dentist practicing outside the state of New Mexico when required by insurance law in that state and when a valid assignment of benefits is received on the individual claim.
4. All benefits not paid to the dentist shall be payable to the enrolled person or to his estate, except if the enrolled person is a minor or otherwise not competent to give a valid release, benefits may be payable to his parent, guardian or other person actually supporting him.

5. Delta Dental must pay directly to the Human Services Department or Indian Health Services any eligible dental benefits under this Contract which have already been paid or are being paid by the Human Services Department or Indian Health Services on behalf of the enrolled employee under the State's Medicaid Program or Indian Health Program.
6. In cases of a qualified medical child support order (QMCSO), Delta Dental will direct benefit payments to the provider when the services are rendered by a participating dentist. Payment of benefits for services obtained from non-participating providers will be directed in compliance with the valid order of judgment provided in the QMCSO.

G. Right to Recover Benefits Paid by Mistake

If Delta Dental makes a payment to the enrolled person or to a dentist and the patient is not eligible for all or part of that payment, Delta Dental has the right to recover the payment from the enrolled person or the dentist who received the payment, on behalf of the Plan. This right to recover a payment includes the right to deduct the amount paid from future dental benefits for any covered family member.

IV. BENEFITS, LIMITATIONS AND EXCLUSIONS

Each benefit category below describes the dental services covered and the most important limitations to that specific category. A dental service will be considered for benefits based on the date the service is started. Benefits are subject to processing policies of Delta Dental and the terms and conditions of the entire Contract. You may refer to Section I, Summary of Benefits, for your patient copayment amounts. Refer to "Limitations on All Services" which lists additional limitations that apply to all categories, as well as "General Limitations and Exclusions".

A. Diagnostic & Preventive Services

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

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

Preventive: prophylaxis (cleaning); periodontal scaling in the presence of gingival inflammation is considered to be prophylaxis for payment purposes; application of topical fluoride; space maintainers; sealants.

Limitations on Diagnostic and Preventive Services

1. Oral examinations, diagnostic consultations and clinical oral evaluations are limited to two (2) per calendar year per enrolled person.
2. Cleanings are limited to two (2) per calendar year per enrolled person. An enrolled person in active periodontal therapy is eligible for two (2) additional periodontal cleanings per year. Children age twelve (12) and over will be considered adults for the purpose of determining benefits for cleanings. When clinically necessary, a once in a lifetime benefit is available for full mouth debridement to enable comprehensive evaluation and diagnosis. Frequency in excess of once per lifetime will be the patient's responsibility.
3. Delta Dental will not pay for full mouth radiographic images if the enrolled person has had full mouth radiographic images within five (5) years. A panoramic radiographic image with or without bitewing images is considered a complete series of radiographic images. Images exceeding the diagnostic equivalent of a complete series of radiographic images will be disallowed when taken on the same date of service. Bitewing radiographic images exceeding the diagnostic equivalent of a complete series of radiographic images will be disallowed when taken on the same date of service.
4. Bite-wing radiographic images are limited to two (2) occurrences per calendar year of up to two (2) sets per enrolled person.
5. Application of topical fluoride is limited to enrolled persons through age eighteen (18) and is limited to two (2) per calendar year.
6. Emergency palliative treatment does not include services and supplies that exceed the minor treatment of pain.
7. Oral examinations, diagnostic consultations, re-evaluation exams and clinical oral evaluations performed in conjunction with an emergency and/or palliative treatment are included in the limit of two (2) exams per calendar year stated above.
8. Diagnostic and preventive services such as diagnostic casts, photographs, laboratory tests, oral hygiene instruction, pulp vitality tests (except in an emergency situation), home fluoride, mounted case analysis, nutrition or tobacco counseling or oral pathology laboratory procedures or reports are not covered.
9. Sealants are limited to dependents through age fifteen (15) for permanent molars free from occlusal restoration.
10. A separate fee for the replacement of a sealant by the same provider is not allowed within three (3) years of the initial placement.

11. Space maintainers are limited to dependents through age eighteen (18) on all dentition. Space maintainers are a benefit once every five (5) years per site.
12. A separate fee for the recementation or repair to a space maintainer by the same provider is not allowed within six (6) months of the original treatment. Six (6) months after the original treatment date, recementation or repair is a benefit once per twelve (12) month period.
13. A separate fee for the removal of a space maintainer by the same provider who placed the initial appliance is not allowed. Removal of a space maintainer by a different provider is a benefit once per lifetime per space.
14. Final fill radiographic images performed on the same day as root canal therapy are a covered dental service.
15. Refer to "Limitations on All Services" and "General Limitations and Exclusions" for additional provisions that may apply.

B. Additional Benefits for Patients with Specified Medical Conditions

Delta Dental may pay for additional benefits for people with specified medical conditions.

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 – chemotherapy/radiation treatment, HIV positive, organ transplants, and stem cell (bone marrow) transplants
    e. Head and neck radiation patients
    f. Individuals 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. Individuals 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. Individuals with pulmonary shunts or conduits
    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 to notify your dentist of these or any other serious medical conditions and to discuss what treatment options may be right for you.

C. Restorative Services

Amalgam and resin-based composite restorations (fillings) and prefabricated stainless steel restorations for treatment of visible destruction of the hard tooth structure resulting from the process of decay.

Limitations on Restorative Services

1. Replacement of a restoration on a tooth for the same surface by the same provider is not covered if done within twenty-four months of the initial service.
2. Bases, direct and indirect pulp caps are considered part of the restoration. A separate fee is not covered.
3. Sedative or temporary fillings done on the same day as the permanent restoration are not covered.
4. Services for two (2) or more surface metallic, porcelain/ceramic or composite/resin onlays are subject to professional review and "Limitations on Optional Services".
5. Replacement of existing restorations for any purposes other than restoring active tooth decay or fracture is not covered.
6. Refer to "Limitations on All Services" and "General Limitations and Exclusions" for additional provisions that may apply.

D. Basic Services

Extractions: surgical and non-surgical extractions.

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

Anesthesia: intravenous sedation and general anesthesia.

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

Periodontic: treatment of diseased gums and bones supporting teeth.

Repairs and adjustments to crowns, bridges and dentures.

Limitations on Basic Services

1. A quadrant is defined as four (4) teeth for purposes of benefit calculation.
2. Intravenous (IV) sedation and general anesthesia are not covered for non-surgical extractions and/or patient apprehension.
3. Intravenous (IV) sedation and general anesthesia are benefits only when administered by a licensed dentist in conjunction with certain covered surgical procedures (certain 7000 series procedure codes) and when medically necessary as defined by Delta Dental.
4. A separate fee is not allowed for pulp therapy procedures or a temporary filling when performed on the same day, by the same provider, as root canal therapy.
5. A gingivectomy performed on the same date of service as a restoration is an eligible expense subject to professional review.
6. A separate fee for analgesia, euphoric drugs or local anesthesia is not covered.
7. Benefits for certain oral surgery procedures (7340-7799 and 7900-7999) are subject to the receipt of an operative report and reduced by benefits provided under the patient's medical coverage if applicable.
8. A separate fee is not allowed for chemotherapeutic agents or biologic materials.
9. Re-treatment of root canal therapy or re-treatment of surgical procedures involving the root, by the same dentist, within twenty-four (24) months, is considered part of the original procedure and is not covered as a separate benefit.

10. Re-treatment of root canal therapy surgical procedures involving the root, performed by a different dentist within twenty-four (24) months, will be considered when received with supporting documentation.
11. Tooth transplantation or implantation is not covered.
12. Periodontal scaling and root planing are limited to once per quadrant in a two (2) year period, based on the dates of service.
13. Periodontal surgery, such as gingivectomy, gingival flap, crown lengthening, osseous surgery, mucogingival surgery, bone grafts and tissue graft procedures are limited to once per quadrant in a three (3) year period.
14. Periodontal procedures may be subject to professional review of documented periapical radiographic image and pocket charting as determined by Delta Dental.
15. A separate fee for distal/proximal wedge, curettage, scaling, root planing, gingivectomy, clinical crown lengthening, osseous contouring and flap procedures are not covered services when performed on the same day as surgical procedures in the same anatomical area.
16. A separate fee for an alveoloplasty is not a covered benefit when performed on the same day as a surgical extraction(s).
17. A separate fee for recementation of a crown, onlay, inlay, or bridge is not allowed within six (6) months of the seating date. Recementations are a benefit once in a twelve (12) month period.
18. A separate fee for repairs to crowns, bridges and dentures within six (6) months of placement is not allowed. Repairs to crowns, bridges and dentures are a benefit once in a twelve (12) month period.
19. Refer to "Limitations on All Services" and "General Limitations and Exclusions" for additional provisions that may apply.

E. Major Services

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

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

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

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

Limitations on Major Services

1. Replacement of any crowns, cast restorations, build-ups, implants, substructures or veneers is not a benefit within five (5) years of previous replacement.
2. Replacement of any bridge or denture is not a benefit if the previous placement is less than five (5) years old.
3. A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means. Benefits for specialized denture techniques, such as overdentures or specialized materials, are limited to the benefit applicable to a standard partial or complete denture.
4. A separate fee for the recementation or repair to crowns, implants, onlays, or bridges within six (6) months of the original treatment by the same provider is disallowed. After six (6) months, these services are a benefit once per twelve (12) months.
5. Surgical placement of eposteal or transosteal implants is not a benefit.

6. Surgical placement of an endosteal implant is a benefit once per tooth per five (5) year period.
7. Implant retained or supported crowns and retainers with metallic alloy content less than high noble are not benefits.
8. Implant maintenance procedures are limited to twice in a benefit period.
9. The replacement of a semi-precision or precision attachment of an implant/abutment supported prosthesis is considered a specialized procedure and is not a benefit.
10. A separate fee for the removal of an implant within twenty-four (24) months of the original placement, by the same provider, is disallowed. After twenty-four (24) months, this service is a benefit once per tooth per lifetime.
11. A separate fee is not allowed for a radiologic surgical implant index.
12. Relines and rebases are a benefit once in a three (3) year period.
13. 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.
14. Temporary restorations, temporary implants and temporary prosthodontics are not benefits.
15. Initial prosthetic placement for congenitally missing teeth is not covered.
16. Maxillofacial prosthetics are not a benefit.
17. Crowns, implants and prosthodontics are not benefits for children under the age of sixteen (16).
18. Fees for full or partial dentures include any reline/rebase, adjustment or repair required within six (6) months of delivery except in the case of immediate dentures.
19. Tissue conditioning is not a benefit more than twice per denture unit in a three (3) year period.
20. A separate fee for tissue conditioning is not allowed if performed on the same day a denture is delivered or a reline/rebase is provided.
21. Refer to "General Limitations and Exclusions" for additional provisions that may apply.

F. Orthodontic Services

Orthodontic Services means procedures performed by a dentist using appliances to treat poor alignment of teeth and their surrounding structure, which significantly interferes with their function.

Any amount paid towards the benefit Maximum for all other services covered under the Plan does not apply to Orthodontic Services. Any amount for Orthodontic Services that exceeds the lifetime maximum is your responsibility. Please refer to the Summary of Benefits for the specific and lifetime benefit provisions for Orthodontic Services.

Diagnostic casts will be considered for payment at the Diagnostic and Preventive Services copayment level when performed in conjunction with covered Orthodontic Services. Payments for diagnostic casts are part of the orthodontic lifetime maximum.

Limitations on Orthodontic Services

1. If the enrolled person is already in orthodontic treatment, benefits shall commence with the first treatment rendered following the patient's effective date. Charges incurred prior to the patient's effective date are disallowed.
2. Benefits will end immediately if orthodontic treatment is stopped or upon termination of coverage.
3. Charges to repair or replace any orthodontic appliance are not covered, regardless if the appliance was a covered benefit under this plan or any other.

4. Charges for radiographic images (except for cephalometric film) or extractions are not covered under this rider. These services may be covered under Diagnostic and Preventive Services or Basic Services described in this Summary Plan Description.

G. General Limitations and Exclusions

1. Services beyond treatment that is considered the standard of care customarily provided are considered "optional or specialized services." These services may include the use of alternative techniques, special materials, and services of a cosmetic intent.
2. If a Plan Participant receives optional or specialized services, benefits will be determined based on the customary or standard procedure. A determination of optional or specialized services is not to be interpreted as an opinion or judgment on the quality or durability of the service. The Plan Participant will be responsible for any difference between the cost of optional or specialized services and any benefit payable.
3. Unless stated otherwise, all frequency limitations are measured from the last date a procedure was performed according to the patient's dental records.
4. 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.
5. Services for congenital or developmental malformations are not covered. Such malformations include, but are not limited to, cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), and fluorosis (a type of discoloration of the teeth). Services provided to newborn children enrolled from birth for congenital defects or birth abnormalities are not, however, excluded from coverage.
6. Treatment to restore tooth structure lost from wear unless there is visible decay or fracture on the tooth structure is not covered.
7. Cosmetic surgery or procedures are not covered.
8. Prosthodontic services or any single procedure started before the patient is covered under the Plan are not eligible for benefits.
9. Prescribed drugs, pain medications, desensitizing medications and therapeutic drug injections are not covered.
10. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dental or medical provider for treatment in any such facility are not covered services.
11. Extra oral soft tissue grafts (grafting of tissues from outside the mouth to oral tissues) or bone graft accession from a donor site are not a benefit.
12. Orthodontic services are not covered unless stated in the Summary of Benefits.
13. Treatment of the temporomandibular joints (TMJ) is not a covered expense.
14. Treatment must be provided by a licensed dentist or a person who by law may work under a licensed dentist's direct supervision.
15. A separate charge for office visits, non-diagnostic consultations, case presentations or broken appointments is not covered.
16. Treatment to correct harmful habits is not covered.
17. A separate charge is not allowed for behavior management, infection control, sterilization, supplies, and materials.
18. Charges for services or supplies that are not necessary according to accepted standards of dental practice are not benefits.

19. Charges for services, supplies, or devices which are not a dental necessity are not benefits.
20. Procedures considered experimental or investigational, as determined by Delta Dental, are not covered.
21. A hemisectioned tooth will not be benefited as two (2) separate teeth.
22. Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion is not a benefit.
23. Treatment to stabilize teeth is not a benefit.
24. Occlusal or athletic mouth guards are not a benefit.
25. Replacement of existing restorations for any purposes other than restoring active tooth decay or fracture is not covered.

V. COORDINATION OF BENEFITS

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

An enrolled person will provide Delta Dental with the necessary information needed to administer COB. Delta Dental may release required information or obtain required information in order to coordinate the benefits of an enrolled person.

A. Determining Which Plan is Primary

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

1. Medicaid or Indian Health Services - Delta Dental is always the primary plan to any benefits payable by Medicaid or Indian Health Services.

2. Non-coordinating Plans – If you have another plan that does not coordinate benefits, it will always be the primary plan.
3. Hospital, surgical/medical, or prescription drug plans: are the primary plan if the plan provides benefits for dental related services including but not limited to: treatment due to accidental injuries, surgical extraction of impacted wisdom teeth, oral surgery, the administration of general anesthesia.

4. Employee or Subscriber: The plan that covers the enrolled person other than as an enrolled dependent is primary. For example, the plan that covers you as the employee or subscriber, neither laid off nor retired, is the primary plan

5. Children and the Birthday Rule: The plan of the parent whose birthday is earliest in the calendar year is always primary for children. For example, if your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your children. If both parents have the same birthday, the plan that has covered the parent for the longer period will be primary.

6. Children with Parents Divorced or Separated

    a. If a court decree makes one parent responsible for health care expenses, that parent's plan is primary.

    b. If a court decree states that the parents have joint custody without stating that one of the parents is responsible for the child's health care expenses, Delta Dental follows the

birthday rule (see rule 5 above. If neither of these rules applies, the order will be determined as follows:

i. First, the plan of the parent with custody of the child;
ii. Then the plan of the spouse of the parent with custody of the child;
iii. Next, the plan of the parent without custody of the child; and
iv. Last, the plan of the spouse of the parent without custody of the child.

7. Laid Off or Retired Enrollees

a. The plan that covers the enrollee as a laid off or retired employee or as a dependent of laid off or retired employee.

8. COBRA Coverage

b. The plan that is provided under a right of continuation pursuant to federal or a similar state law (that is COBRA).

9. Other Plans

c. If none of the rules above determines the order of benefits, the plan that has covered the enrollee for the longer period will be primary.

B. How GSD/RMD Pays as Primary

When GSD/RMD is the primary plan, Delta Dental will pay for covered services as if you had no other coverage.

C. How GSD/RMD Pays as Secondary

When GSD/RMD is the secondary plan, it will pay for covered services based on the amount left after the primary plan has paid. It will not pay more than that amount, and it will not pay more than it would have paid as the primary plan. However, GSD/RMD may pay less than it would have paid as the primary plan.

D. Right of Recovery

If GSD/RMD pays more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The people it has paid or for whom it has paid;

a. Insurance companies; or

b. Other organizations.

VI. SUBROGATION OF BENEFITS

If a third party has caused or contributed to an injury or illness and may be responsible for payment of covered dental expenses, the Plan has the right to subrogation and reimbursement, to the maximum extent permitted by law, for covered expenses it has paid for an injury or illness caused (or purportedly caused) by an act or omission of a third party. A third party does not have to be found to be legally responsible in order for the Plan to assert its subrogation and reimbursement rights against amounts paid by a third party or insurer.

The Plan shall succeed to the rights of any enrolled person against any other plan, person, or entity for recovery of dental care expenses for which such other plan, person or entity is liable. All amounts so recovered, by settlement, judgment or otherwise, shall be paid to the Plan, for ultimate disposition thereunder, which may include payment to GSD/RMD.

Enrolled persons shall furnish such information, execute and deliver such assignment document and other instruments, and take whatever steps are necessary to secure the rights of the Plan and GSD/RMD. Enrolled persons shall take no action to prejudice the rights and interests of the Plan or GSD/RMD hereunder.

VII. CLAIMS APPEAL

A. Voluntary Appeal Procedure

If you think Delta Dental incorrectly denied all or part of your claim, you may request a review through Delta Dental's Claim Appeal procedure. All of the Claim Appeal procedures are voluntary and are designed to provide a full and fair review of any adverse benefit determination. An adverse benefit determination means a denial, reduction or termination of a benefit or a failure to make payment, in whole or in part, for a benefit. This includes a determination based on the enrolled person's eligibility to participate in the Plan.

Your decision as to whether or not to submit an adverse benefit determination to these voluntary levels of appeal will have no affect on your right to any other benefits under the Plan. In addition, you are assured of the following provisions:

1. You will be notified in writing by Delta Dental of any adverse benefit determination and the reason for the adverse determination.
2. You may submit written comments, documents, records, narratives, radiographs, clinical documentation and other information relating to your claim which Delta Dental will take into consideration, whether or not such information was submitted or considered in the initial benefit determination.
3. You shall be provided, upon request and free of charge, reasonable access to and/or copies of all documents, records and other information in the possession of Delta Dental that is relevant to your claim.
4. You may choose a representative to act on your behalf at your own expense.
5. You will not be charged any fees or costs incurred by Delta Dental or the Plan as part of the voluntary appeals process.
6. You have 180 days following receipt of a notification of an adverse benefit determination within which to appeal.
7. Delta Dental will respond to your appeal in writing within 30 days of receipt of your request.
8. You are not required to file an appeal to Delta Dental prior to arbitration or taking civil action.
9. The review of any adverse benefit determination under appeal will not be conducted by the same individual or a subordinate of the individual who determined the initial adverse benefit determination.

B. Informal Claim Review Process

Many problems may be handled informally by calling Delta Dental's Customer Service at (505) 855-7111 or toll free at (877) 395-9420. You always have the opportunity to describe problems, submit explanatory information and allow Delta Dental to correct any errors quickly and without delay.

C. Formal Claim Appeal Process

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

1. Appeal of Claim Processing Procedure means you are requesting a review of Delta Dental's application of an administrative, procedural, or Contract/benefit provision that resulted in an adverse benefit determination.

   You may appeal an adverse benefit determination by sending a request in writing to Delta Dental describing your reasons for requesting a review and including any additional information you wish to be considered. A Delta Dental representative, who is neither the individual who made the initial claim determination nor the subordinate of such individual, will conduct a review of your claim. The results of the review will be provided in writing to you and to your treating dentist as appropriate.

2. Appeal of Claims for Dental Treatment means you are requesting a review of Delta Dental's professional review of a dental treatment by Delta Dental's licensed dental consultant that resulted in an adverse benefit determination. Three voluntary options for appeal are available to you:

   a. You may appeal an adverse benefit determination by sending a request in writing to Delta Dental, describing your reasons for requesting a review and including any additional information you wish to be considered. A licensed dental consultant, who is neither the individual who made the initial claim determination nor the subordinate of such individual, will provide a full and fair independent review of the claim.

      If the consulting dentist agrees the treatment is dentally necessary, Delta Dental will re-calculate your claim for available benefits and send written notification of payment to you and your treating dentist. In the event the consulting dentist determines the treatment is not dentally necessary according to the terms of the Contract or standard dental treatment, the adverse benefit determination will be upheld. Delta Dental will send notification to you and to your treating dentist as appropriate.

   b. You may appeal an adverse benefit determination and request an independent oral examination by writing to Delta Dental, describing your reasons for requesting a review and including any additional information you wish to be considered. A licensed dental consultant, who has neither been involved in previous determinations of the claim under review nor is a subordinate of such individual, will provide a full and fair independent review of the claim.

      If the consulting dentist agrees the treatment is dentally necessary, Delta Dental will recalculate your claim for available benefits and send written notification of payment to you and your treating dentist.

      In the event the consulting dentist determines the treatment is not dentally necessary according to the terms of the Contract or standard dental treatment, an oral examination will be scheduled with a licensed dentist who has not been involved with any previous benefit determinations. The fee for this oral examination will be the responsibility of the Plan and will not apply to the frequency limitations on exams under the Contract provisions. If the examining dentist agrees the treatment is dentally necessary, Delta Dental will recalculate your claim for available benefits and send written notification of payment to you and your treating dentist. In event the examining dentist determines the treatment is not dentally necessary according to the terms of the Contract or standard dental treatment, the adverse benefit determination will be upheld. Delta Dental will send written notification to the enrolled employee and to the treating dentist as appropriate.

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

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

State of New Mexico Appeal Procedures

If you are not satisfied with Delta Dental's decision under either category above, you may appeal the decision by filing a formal written appeal to the State of New Mexico's Risk Management Division (RMD) within 30

days of the day the appeal decision was made by Delta Dental. Upon receipt of the appeal request, RMD will review the case and respond to the parties involved within 30 days. Appeals to RMD should be sent to:

Risk Management Division,
Employee Benefits Bureau
P.O. Box 6850
Santa Fe, New Mexico 87502

VIII. TERMINATION OF COVERAGE

A. When Coverage Ends

Coverage ends on the last day of the pay period in which premium payment has been made for an enrolled employee who loses coverage due to:

1. loss of eligibility;
2. voluntarily canceling coverage;
3. cancellation of the Contract by GSD/RMD or Delta Dental;
4. GSD/RMD advises Delta Dental to terminate your coverage.

An enrolled dependent loses coverage along with the enrolled employee, or on the last day of the pay period in which premium payment has been made when they lose dependent status, whichever is earlier. An enrolled person and/or dependents may be eligible to continue coverage if certain conditions are met. Please refer to "Continuation of Coverage" in this Summary Plan Description.

B. When Benefits End

If an enrolled person loses coverage, the Plan will pay benefits only for covered services incurred prior to the cancellation date. Claims must be submitted to Delta Dental in writing within 90 days after the services have been provided and for which benefits are payable. Delta Dental will not continue to pay benefits for any enrolled person if this Contract is canceled for any reason.

IX. CONTINUATION OF COVERAGE

The State of New Mexico benefit plans are subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. This means that enrolled employees and/or enrolled dependents may be entitled to continue coverage under this dental program following certain "Qualifying Events" if certain conditions are met.

To be eligible for continued coverage, an employee or dependent must be enrolled in this dental program on the day before the Qualifying Event occurs, except for a child born to or placed for adoption with a COBRA-enrolled person during the period of continuation coverage. Such child shall be treated like all other COBRA-enrolled persons.

The employee or dependent has the responsibility to inform the Human Resource Group Representative within 60 days of the date of the Qualifying Event (divorce, death or a child losing dependent status, as listed below) or the date on which coverage would end under the program because of the Qualifying Event, whichever is later. Your option to continue coverage will be lost if you fail to notify your Human Resource Group Representative. Your Human Resource Group Representative has the responsibility to notify GSD/RMD of the employee's death, termination of employment, reduction in hours or Medicare entitlement.

Your Human Resource Group Representative will advise you of your rights to continue coverage upon becoming aware of your "Qualifying Event". You will be told how much you'll be charged to continue coverage as permitted by federal law, which may not exceed 102% of the premium for an active employee.

Under the law, you have to pay the applicable premium for your continuation coverage. There is a grace period of 30 days for payment of the regularly scheduled premium.

If you wish to continue coverage, you must submit a completed and signed enrollment form to GSD/RMD. You have 60 days from the date you would lose coverage because of one of the events described above, or the date notice of your election rights is sent to you, whichever is later, to elect continuation coverage on the forms provided.

If you do not choose continuation coverage, your dental insurance will end.

If you choose continuation coverage, GSD/RMD is required to give you coverage, which as of the time coverage is being provided, is identical to the coverage provided under the dental program to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lose group coverage because of termination of employment or a reduction of hours. In that case, the required continuation coverage period is 18 months. This 18 months may be extended to 36 months if you experience a second qualifying event. The chart below illustrates the duration of COBRA eligibility for employees and dependents based on the type of qualifying event. In no event will coverage extend beyond 36 months after the initial qualifying event. You should notify GSD/RMD if a second qualifying event occurs during your period of continuation coverage.

Length of COBRA Continuation Coverage

The chart below summarizes the length of continuation coverage to which an employee or dependent is entitled as a qualified beneficiary:

Qualified Beneficiary	Length of Coverage	Initial Qualifying Event
The employee and their dependents including newborns and adopted children	- 18 months from the date of the qualifying event - an additional 11 months if you become disabled within the first 60 days of the qualifying event	-reduction in work hours -termination of employment
Dependents including newborns and adopted children	- 36 months from the date of the qualifying event	- divorce or legal separation - child's loss of dependent status - entitlement to Medicare - death
The employee and their dependents	- an additional 11 months, or a total of 29 months from the date of the qualifying event which started the COBRA continuation coverage	- if before or within 60 days of the initial COBRA continuation coverage, the employee (or their dependent) become disabled, coverage may be extended for 11 months
Dependents	- an additional 18 months or a total of as many as 36 months from the date of the first qualifying event	- if the dependent has already elected 18 months of COBRA coverage and experiences a second qualifying event, coverage may be extended to 36 months from the first qualifying event

However, the law also provides that your continuation coverage may be terminated for any of the following reasons:

- Your employer no longer provides group dental coverage to any of its employees;
- The premium for your continuation coverage is not paid on time;
- You become covered by another group plan that begins coverage after your COBRA election that
  - does not contain any pre-existing condition exclusion or limitation applicable to you, or

- contains any exclusions or limitations with respect to any pre-existing condition, but it does not apply to you or your covered dependents (or it is satisfied by him or her); or

- You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage is provided subject to your eligibility for coverage under the dental plan. GSD/RMD reserves the right to terminate your continuation coverage retroactively if you are determined ineligible.

Once your continuation coverage terminates for any reason, it cannot be reinstated.

This is a summary of the law and therefore is general in nature. The law itself and the actual provisions of the dental plan must be consulted with regard to the application of these provisions in any particular circumstances. If you have any questions, please contact your Human Resource Group Representative. Also, if you have had a change in familial status, or you/your spouse have changed addresses, please notify your Human Resource Group Representative.

X. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

GSD/RMD (the "Plan Sponsor") sponsors this group dental plan (the "Plan"). Designated employees of GSD/RMD have access to the individually identifiable health information of Plan participants for administrative functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information (PHI).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor's ability to use and disclose PHI. The following HIPAA definition of PHI applies to this plan amendment:

> *Protected Health Information* means information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Plan Sponsor shall have access to PHI from the Plan only as permitted or required by HIPAA or pursuant to a covered person's authorization.

A. Permitted and Required Uses and Disclosure of Protected Health Information For Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described in paragraph B and obtaining written certification pursuant to paragraph D, the Plan may disclose PHI to the Plan Sponsor, provided that the Plan Sponsor uses or discloses such PHI only for Plan administration purposes. "Plan administration purpose" means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit plan of the Plan Sponsor, and they do not include any employment-related functions.

B. Conditions of Disclosure for Plan Administration Purposes

The Plan may allow the Plan Sponsor limited access to PHI as follows:

- Enrollment and disenrollment information, and

- Summary Health Information which means information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided benefits under the group plan, and from which individually-identifiable health information has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.

Plan Sponsor agrees that with respect to any PHI, other than enrollment/disenrollment information and Summary Health Information which are not subject to these restrictions, disclosed to it by the Plan, shall:

- not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524;
- make available PHI for amendment and incorporate any amendments PHI in accordance with 45 CFR §164.526;
- make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
- if feasible, return or destroy all PHI received from the Plan that the Plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- ensure that the adequate separation between Plan and Plan Sponsor (i.e., the "firewall"), required in 45 CFR §504 (f)(2)(iii), is satisfied.

C. Adequate Separation Between Plan and Plan Sponsor

The Plan Sponsor shall allow the Director of GSD/RMD, and staff designated by the Director, access to the PHI. No other persons shall have access to PHI. These specified employees shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

D. Certification of Plan Sponsor

The Plan shall disclose PHI to the Plan Sponsor only upon the receipt of certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in paragraph B of this Section.

XI. DEFINITIONS

Benefit Period means the time period for accumulating the deductible and benefit maximum.

Benefits means the amount the Plan will pay for covered dental services described in Benefits, Limitations and Exclusions.

Calendar Year means the period of 12 months beginning on January 1 and ending on December 31 of each year.

Contract means the Professional Services Agreement between Delta Dental and the GSD/RMD.

Covered and Allowed Amount means the maximum dollar amount determined by Delta Dental and considered for each dental procedure before application of copayment and deductible and is based on the lesser of the PPONew Mexico Schedule of Fees or the dentist's billed amount.

Deductible means the amount an enrolled person must pay towards covered services before the Plan begins paying towards covered benefits.

Delta Dental means Delta Dental Plan of New Mexico, Inc.

DeltaPremier Dentist means a dentist who has signed a DeltaPremier Participating Dentist Agreement and agreed to accept the Delta Maximum Approved Amount or the contractually agreed upon amount with Delta Dental in the state where services are provided.

Delta Maximum Approved Amount means the maximum fee allowed as determined by Delta Dental and agreed to by DeltaPremier dentists for each single procedure.

Dental Necessity means a service or supply provided by a dentist or other provider that has been determined by Delta Dental as generally accepted dental practice for the enrolled person's diagnosis and treatment. Delta Dental may use dental consultants to determine generally accepted dental practice standards and if a service is a dental necessity. These services or supplies are in accordance with generally accepted local and national standards of dental practice, and not primarily for the convenience of the enrolled person or provider. The services/supplies are the most appropriate that can safely be provided. The fact that a provider has performed or prescribed a service or supply does not mean it is a dental necessity.

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

Effective Date means the date the Plan starts.

Eligible Dependent means a person who meets the conditions of eligibility outlined in Eligibility and Enrollment, whether or not they actually enroll.

Eligible Employee means an employee who meets the conditions of eligibility outlined in Eligibility and Enrollment, whether or not they actually enroll.

Enrolled Dependent means a dependent of an enrolled employee who meets the conditions of eligibility outlined in Eligibility and Enrollment, whose completed enrollment information has been received by Delta Dental.

Enrolled Employee means any employee who meets the conditions of eligibility outlined in Eligibility and Enrollment, whose completed enrollment information has been received by Delta Dental.

Enrolled Person means either an enrolled employee, enrolled dependent or COBRA-enrolled person.

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

- A technology must have final approval from the appropriate regulatory governmental bodies;
- The scientific evidence as published in peer-review literature must permit conclusions concerning the effect of the technology on health outcome;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and
- The technology must be attainable outside the investigational settings.

Maximum means the total dollars payable by the Plan for covered dental services in a benefit period or lifetime period for each enrolled person.

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

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

Participating Dentist means a dentist who is a member of Delta Dental and who has agreed to abide by a Delta Dental Participating Dentist Agreement.

Patient Copayment means the percentage of the payment due to the dentist for a covered service which is the enrolled person's responsibility.

PPONew Mexico dentist means a participating dentist who has specifically agreed with Delta Dental to participate in the PPONew Mexico Schedule of Fees plan.

PPONew Mexico Schedule of Fees means the maximum fee allowed as determined by Delta Dental and agreed to by PPONew Mexico participating dentists for each single procedure.

Pre-treatment Estimate of Benefits means an advance notification of benefits payable under the Plan as requested by the attending dentist prior to performing a recommended treatment for a covered person. A pre-treatment estimate of benefits is subject to all maximums, deductibles, eligibility and all other plan provisions at the time services are actually performed. A pre-treatment estimate of benefits is not required as a condition for payment of benefits.

Provider means a legally licensed dentist or any other legally licensed dental practitioner, rendering services which are covered under the Contract and are within the scope of the individual's license.

Services and Supplies means those services, devices, or supplies that are considered safe, effective, and appropriate for the diagnosis or treatment of the existing condition. This does not include experimental services, devices, or supplies. The Plan reserves the right to make the final decision as to whether services, supplies or devices are experimental under this definition.

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

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