



Delta Dental Plan of New Mexico, Inc.

Summary Plan Description

for the State Employees of New Mexico

NOTICE: This Dental Benefit Handbook (“Summary Plan Description”), along with the attached Group Requirements and Summary of Benefits, describes important Dental Benefit Plan provisions. To the extent that any rules or requirements set forth in this Summary Plan Description conflict with those prescribed by the attached Group Requirements or the Summary of Benefits, the rules or requirements prescribed by the attached Group Requirements and the Summary of Benefits will control.

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Summary Plan Description

Delta Dental Plan of New Mexico, Inc.

This Summary Plan Description, the Summary of Benefits and attached Group Requirements (collectively “Plan”), describe important provisions for your Dental Benefits Plan that is administered by Delta Dental Plan of New Mexico, Inc. (“Delta Dental”, “Delta Dental New Mexico”, or “DDNM”).

Dental 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 benefits plan 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 shall apply to all Enrolled Persons at the time of such change.

Delta Dental New Mexico has been selected by the Group to process claims under the Plan. Delta Dental New Mexico does not serve as an insurer, but as a claims processor. Claims for benefits are sent to Delta DDNM for Benefit determinations, processing, and payment. DDNM also supports the Group with enrollment, local customer service, and access to the Delta Dental Provider Network(s) selected by the Group. Delta Dental 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 Summary Plan Description, along with the Summary of Benefits and the attached Group Requirements, describe important Plan provisions. To the extent that anything set forth in this SPD conflicts with the Summary of Benefits or the attached Group Requirements, the Summary of Benefits and the attached Group Requirements will control. Any modification to the Plan will apply to all Enrolled Persons covered by the Plan at the time of such change.

For answers to questions or assistance about Benefits, contact Delta Dental New Mexico as follows:



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, well-being, and smile are important to us. This Plan is designed to promote regular dental visits and utilization. Take advantage of your Benefits by calling a Delta Dental Provider today for an appointment.

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NOTICE: This Summary Plan Description, along with the attached Group Requirements and Summary of Benefits, describes important Dental Benefit Plan provisions. To the extent that any rules or requirements set forth in this Summary Plan Description conflict with those prescribed by the attached Group Requirements or the Summary of Benefits, the rules or requirements prescribed by the attached Group Requirements and the Summary of Benefits will control.

I. Introduction

Your Employer entered an administrative services agreement with Delta Dental New Mexico to provide you with dental benefits as one of the benefits of your employment. The Benefits will assist you with many of your eligible expenses for Covered Services for dental services under the Plan.

Take time to read, review, and reference this Summary Plan Description, the Summary of Benefits and the attached Group Requirements (collectively “Plan”) so that you will understand the Benefits, limitations, exclusions, and your responsibilities.

You are covered only for those Benefit categories, Benefit percentages, and Services shown in the Summary of Benefits. The Benefit percentages for each category of Covered Services are shown in the Summary of Benefits along with information about the available Delta Dental Provider Networks under the Plan. Defined terms are capitalized and shown in Definition Section and various Plan Sections.

If you have any questions or need help, contact our **Local Customer Service Team** available from 8:00 AM to 4:30 PM (Mountain Time), Monday through Friday, to:

- Answer any questions about the Plan, Benefits, Claims, or Services;
- Provide information or assistance;
- Help you find a Delta Dental Provider near you;
- Get or find help in completing or submitting a Claim Form;
- Understand an Explanation of Benefits or other communication; and
- Request an appeal, or file a complaint or grievance.

Call, email or write our **Local Customer Service Team**:



Toll Free **1-877-395-9420** or Locally **1-505-855-7111**



customerservice@deltadentalnm.com



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

Also, visit our website at deltadentalnm.com, 24 hours a day, 7 days a week. The website has helpful information, and you access forms and more. Through the website, you can also register and access the secure online Member Portal at deltadentalnm.com/Members/Member-Portal.aspx that gives you a range of self-service options such as:

- Reviewing your specific Benefits, including eligibility for Dependents;
- Finding current information about your Benefits, such as how much of your Annual Maximum Limit or Lifetime Maximum Limit has been used to date, how much is still available to use, and levels of coverage for specific Services;
- Reviewing Claims, reimbursements, payments, and Prior Authorizations;
- Downloading a copy of an Explanation of Benefits (“EOB”) or signing up for electronic delivery of your EOB statements;
- Printing a copy of your ID Card to give to your Dental Provider;

- Searching for Delta Dental Providers; or
- Accessing other information such as how to download our mobile app, use our cost estimator, maintain your oral health wellness, and understand your Benefits.

II. Definitions

Administrative Decision means any decision made about any aspect of the Plan, other than an Adverse Determination, related to: (1) our administrative practices that affect the availability, delivery, or quality of Services; (2) claims payment, handling, or reimbursement for Services including, but not limited to, complaints concerning Co-Pays, Co-Insurance, or Deductibles; and (3) termination of coverage.

Adverse Determination means any of the following: (1) a 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 a covered person's eligibility to participate in the 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 Experimental or Investigational, or not Medically Necessary or appropriate.

Annual Maximum Limit means the maximum dollar amount that Delta Dental New Mexico will pay for Covered Services within a Benefit Period for an Enrolled Person. Any additional cost beyond the Annual Maximum Limit is the responsibility of the Enrolled Person.

Approved Fee means the maximum fee that Delta Dental New Mexico will approve for a Covered Service under an applicable Provider Fee Schedule and the Processing Policies. In all cases, Delta Dental New Mexico will make the final determination regarding the Approved Fee for a Covered Service.

Balance Billing means a business practice adopted by a Dental Provider to collect the difference between the Billed Amount set by the Dental Provider and the reimbursable amount under the Plan, an applicable Provider Fee Schedule, the Processing Policies, and any contract between the Dental Provider and DDNM.

Benefit Period means the period of time during which the Deductible, Annual Maximum Limit, or Lifetime Maximum Limit accumulate, and Frequency Limitations apply, as shown in the Summary of Benefits.

Benefits means the maximum amount that Delta Dental New Mexico can pay for a Covered Service under the terms and conditions of the Plan. Benefits may be expressed in many ways, such as a dollar amount, number of days, or the number of Services. Some Benefits are generally discussed in this SPD but are specified in your Summary of Benefits.

Billed Amount means the amount set by a Dental Provider for a Service, based upon the Dental Provider's desired fee, taxes, costs, overhead, margin, and other factors, that a Dental Provider submits with a Claim and reported as the "Submitted Amount" on an Explanation of Benefits statement.

Child means a child born to or legally adopted by the Subscriber. It also includes a stepchild, grandchild or foster child who lives with the Subscriber, as well as a child for whom the Subscriber is the legal guardian, or collateral Dependent who lives with Subscriber, or a Child supported under a court order imposed on the Subscriber including a qualified medical child support order.

COBRA means the federal “Consolidated Omnibus Budget Reconciliation Act of 1986” that permits certain eligible employees and their families to keep their employer-sponsored group health benefits by their group health plan for limited periods of time under certain circumstances such as a voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events.

Coinsurance means the percentage of the Dental Provider’s approved fee that an Enrolled Person must pay to the Dental Provider after Deductible requirements are met under the Plan. Refer to the Summary of Benefits to determine specified Coinsurance amounts. Coinsurance amounts that you pay, do not apply towards an Annual Maximum Limit or Lifetime Maximum Limit, however the percentage that paid by Delta Dental New Mexico does.

Copayment or **Copay** means a fixed amount that an Enrolled Person must pay for certain Services that may or may not count toward Deductible requirements under the Plan depending upon the Summary of Benefits.

Covered Services means Services that are covered and Medically Necessary and appropriate in accordance with the terms and conditions of the Plan and applicable Processing Policies.

Deductible means the amount that an Enrolled Person must pay toward Covered Services before Delta Dental New Mexico will make any payment for the reimbursement of Covered Services under the Plan. Refer to your Summary of Benefits to determine Deductible amounts.

Delta Dental of New Mexico means Delta Dental Plan of New Mexico, Inc., which is a New Mexico non-profit 501(c)(4) corporation established to provide dental and ancillary services and licensed to transact insurance business in New Mexico as a non-profit health care plan. In this Plan, Delta Dental Plan of New Mexico Inc., is also referenced as “Delta Dental New Mexico”, “Delta Dental of New Mexico”, “DDNM”, “we”, “us” and “our”.

Delta Dental Member Company means dental insurance companies, licensed in various States utilizing the Delta Dental brand, which are members of the Delta Dental Plans Association (“DDPA”).

Delta Dental Provider means a Dental Provider who has entered into an agreement with Delta Dental New Mexico or any Delta Dental Member Company to participate in a Delta Dental Provider Network.

Dental Consultant means a licensed Dental Provider who conducts reviews of Claims to verify that Services are Medically Necessary and appropriate under the terms and conditions of the Plan and Processing Policies.

Dental Insurance means the transfer of risk of eligible financial loss and expenses for Covered Services incurred by an Enrolled Person to Delta Dental New Mexico, whereby Delta Dental New Mexico assumes the risk of eligible financial loss and expenses for Covered Services in consideration of collected Premium under the terms and conditions of the Plan. In other words, as a dental insurer,

Delta Dental New Mexico agrees to reimburse an Enrolled Person for certain amounts of financial losses and eligible expense incurred for Services covered by the Plan during the Term of the Plan.

Dental Provider 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.

Dependent means, unless as otherwise defined in this Plan, an individual relative or child of a Subscriber who relies upon the Subscriber, as a spouse, domestic partner, parent, or guardian for financial support, which is the basis for eligibility for benefits under the Plan if enrolled with and accepted and approved by Delta Dental New Mexico for dental coverage under the Plan.

Effective Date means the date on which coverage goes into effect for an Enrolled Person after Delta Dental New Mexico: (1) receives, accepts, and approves the Application; and (2) receives the required Premium.

Eligible Dependent means a Dependent of a Subscriber who meets the eligibility requirements specified in both the application, the attached Group Requirements, and this Plan.

Eligible Person means a person who is a Subscriber or Dependent who meets the eligibility requirements specified in both the application, the attached Group Requirements, and this Plan.

Enrolled Dependent means an Eligible Dependent that the Subscriber lists on the application and provided enrollment information, which has been received and approved by the Group for coverage under the Plan and the attached Group Requirements, and for whom the Subscriber has paid additional Premium.

Enrolled Person means an Eligible Person who: (1) has met the eligibility requirements specified in the application, the attached Group Requirements, and this Plan as determined by the Group; (2) has been accepted and approved by the Group and Delta Dental New Mexico; and (3) for whom Delta Dental New Mexico has received Premium. An "Enrolled Person" is synonymous with a "Covered Person".

ERISA means the federal "Employee Retirement Income Security Act of 1974" that sets minimum standards for most voluntarily established retirement and health plans in the private industry to provide protect individuals in these plans.

Experimental or Investigational means 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.

Explanation of Benefits ("EOB") means a paper or electronic document provided by Delta Dental New Mexico detailing the Services reimbursed on the Enrolled Person's behalf. Note that an EOB is not a bill.

Grievance means a formal or informal written or verbal complaint that is made by an Enrolled Person or an Enrolled Person's representative about an Adverse Determination or Administrative Decision made by Delta Dental New Mexico under the Plan.

Lifetime Maximum Limit means the maximum dollar amount that Delta Dental New Mexico will pay for Covered Services within the lifetime for an Enrolled Person.

Medical Necessity or Medically Necessary means 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 New Mexico may use Dental Consultants to determine or validate Medical Necessity.

Member means a Subscriber and any Dependent enrolled under the Plan.

Non-Participating Provider means a Dental Provider who has not entered into a formal agreement with Delta Dental New Mexico or any Delta Dental Member Company to participate in any Delta Dental Provider Network. Non-Participating Providers are not subject to the Delta Dental Approved Fees as payment in full and may Balance Bill a patient for the full Billed Amount set by the Non-Participating Provider.

Out-of-Country Dental Provider means an individual who provides Services at a location outside of the United States of America or its territories. Out-of-Country Dental Providers are not eligible to enter into a formal agreement with Delta Dental New Mexico to participate in any Delta Dental Provider Network.

Out-of-Pocket Expense means any expense that an Enrolled Person is responsible for paying for Services.

Patient means Enrolled Person who receives Services from a Dental Provider.

Plan means the Summary Plan Description issued and delivered to the Subscriber that includes the Summary of Benefits, Group Requirements, application, and any attachments, which all describe the terms and conditions of the Dental Benefits available to Enrolled Persons.

Premium means the annual or monthly amount paid by the Subscriber to Delta Dental New Mexico for dental coverage under the Plan.

Prior Authorization means a process performed by Delta Dental New Mexico to determine whether a proposed Service is a Covered Service, Medically Necessary and appropriate, and an estimation of Out-of-Pocket Expense costs under the Plan in accordance with the terms and conditions described in this Summary Plan Description. A Prior Authorization may be requested by an Enrolled Person or an Enrolled Person's Dental Provider.

Processing Policies means policies and procedures that Delta Dental New Mexico maintains to process Prior Authorizations, Claims, and other payments or services pursuant to the Plan, which may be amended from time-to-time by Delta Dental New Mexico.

Service means 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 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.

Spouse means an individual lawfully married to the Subscriber as determined and recognized by the laws of the State of New Mexico.

Subscriber means the person who completes and submits an application for Delta Dental New Mexico's acceptance and approval, meets the eligibility requirements of the Plan (specifically the Group Requirements), pays Premium, and to whom the Plan is issued.

Summary of Benefits means a document that a Subscriber receives as part of the Plan that outlines the specific benefits, limitations, exclusions, cost-sharing requirements, Annual Maximum Limit, Lifetime Maximum Limit, Delta Dental Provider Networks, and other terms and conditions of coverage of Services under the Plan. Simply stated, the Summary of Benefits shows specifically what the Plan covers or does not cover, and what your share of costs will be for Services. The Summary of Benefits is and should be read as part of the Plan. To the extent that anything set forth in the Evidence of Coverage conflicts with the Summary of Benefits, the Summary of Benefits controls.

Summary Plan Description ("SPD") means the detailed agreement that generally describes terms and conditions of the Benefits available to an Enrolled Persons under the Plan. The SPD is and should be read as part of the Plan. To the extent that anything set forth in the SPD conflicts with the Summary of Benefits, the Summary of Benefits will control. (Summary Plan Description is also known as the Dental Benefits Handbook or Evidence of Coverage.)

Qualifying Event means 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.

Teledental Service means 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 Dysfunction (“TMJ”) means dysfunction associated with temporomandibular/craniomandibular structure.

Utilization Review means 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 New Mexico in making coverage determinations, control costs, and monitor quality of care. (Utilization Review is also referred to as clinical review.)

III. Eligibility and Enrollment

This Section explains the eligibility and enrollments required for coverage under this Plan (specifically the attached Group Requirements) as well as Effective Date. Only an eligible and enrolled Subscriber and Dependent(s) may receive Benefits under this Plan.

No person will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, age, race, color, national origin, gender identity, sex, or sexual orientation, religion, or other legally protected status.

A. Determining Eligibility

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

YOU ARE REQUIRED TO NOTIFY US OF ANY QUALIFYING EVENT INVOLVING YOU OR AN ENROLLED DEPENDENT WITHIN 31 DAYS OF THE QUALIFYING EVENT.

- 4. This Plan will allow an annual Open Enrollment period for all Eligible Employees of the Group. **Open Enrollment** means the 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, the Enrolled Person shall provide Delta Dental New Mexico with any information necessary to determine coverage, process claims, and administer Benefits. This includes authorizing Delta Dental New Mexico to have access to an Enrolled Person's dental or other protected records or information.
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 or Group Requirements, 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 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 New Mexico may require proof of the Qualifying Event.

YOU ARE REQUIRED TO NOTIFY US OF ANY QUALIFYING EVENT INVOLVING YOU OR AN ENROLLED DEPENDENT WITHIN 31 DAYS 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.

IV. Accessing Your Benefits

A. Accessing Benefits

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

1. Read, review, and reference this Summary Plan Description, the Group Requirements, 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 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**.
 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 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 staying with the Delta Dental Network.

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 Covered 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. Protection 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 Prior Authorization for 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 Amount¹ 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.

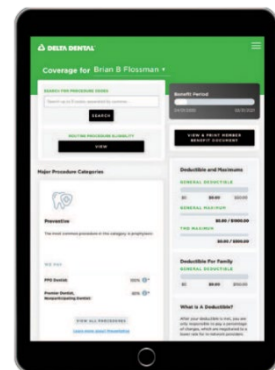
For these reasons, we encourage you to speak with the Non-Participating Provider to understand your potential financial responsibilities before receiving proposed Services. Requesting a voluntary Prior Authorization will help you determine whether proposed Services are Medically Necessary and appropriate, 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 by email at **customerservice@deltadentalnm.com**.

Note: 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 under regulatory standards.

E. 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;



¹ See “Billed Amount” definition in the Definition Section.

- Review an Explanations of Benefits (EOB);
- Download an ID Card; or
- Sign-up for paperless delivery of an EOB Statements.

F. 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.

G. 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 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 DDNM verify the diagnosis with generally accepted dental care standards, subject to applicable limits and exclusions. Requesting a voluntary Prior Authorization will help you 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.

H. 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 you 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. If your Dental 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**.
- 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.

I. 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. DDNM can assist you and your Dental Provider assess the financial aspects of Services and verify that Services are covered. This Subsection describes everything you need to know to request a Prior Authorization.

1. Prior Authorization vs. Pre-Treatment Estimate

Dental Insurance can be confusing in how it uses terms such as pre-determinations, 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 DDNM 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 at a point in time and as voluntarily requested by you or your Dental Provider.

3. What is Prior Authorization designed to do? 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, DDNM recommends 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 is another 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 by email at **customerservice@deltadentalnm.com** if you have questions or need assistance.

5. What are the advantages 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. What is the timeliness of review and decision of a Prior Authorization?

Once DDNM receives your complete Prior Authorization request, Delta Dental of New Mexico will make a decision within five (5) business days and notify you and your Dental Provider. If DDNM is 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, DDNM 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. Does a Prior Authorization guarantee coverage?

Approval of a Prior Authorization guarantees coverage and reimbursement if your medical condition, coverage, or utilization does not change. DDNM 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. Can you ask for a review of a Prior Authorization?

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 by email at **customerservice@deltadentalnm.com**. Most of the time, DDNM can answer your questions, provide information, address your issues, and correct errors quickly. If you remain dissatisfied, you may appeal a Prior Authorization determination under our “Adverse Determination” process described below.

J. 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 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 Services that exceed the Maximum Benefit Amount applicable in the Benefit Period. The Maximum Benefit Amount is stated in the Summary of Benefits.

V. 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 DDNM has 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, or complaints 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.

DDNM's Claim processes are designed to help you and your Dental Provider manage the financial aspects of Services and ensure that Services are appropriately covered under the Plan. DDNM 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, DDNM 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 DDNM.

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 DDNM to make the direct payment under your designation, otherwise payment will be made to you. You will receive an EOB indicating whether DDNM 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 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 DDNM's 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 DDNM 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 DDNM.

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, DDNM 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. DDNM calculates 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 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 will 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 by email at customerservice@deltadentalnm.com.


D. Claim Processing

1. When DDNM receives 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 DDNM may have with the Dental Provider, and other applicable requirements.
2. DDNM 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 DDNM 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 DDNM 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.



Explanation of Benefits (THIS IS NOT A BILL)

A 

Patient Name: [REDACTED]
 Date of Birth: xx/xx/xxxx
 Relationship: SUBSCRIBER
 Subscriber: [REDACTED]

Business/Dentist: [REDACTED]
 License No.: [REDACTED]
 Check No.: [REDACTED]
 Issue Date: [REDACTED]
 Receipt Date: [REDACTED]
 Claim No.: [REDACTED]

Pay To: C = Custodial Parent
 S = Subscriber
 P = Provider
 A = Alternate Provider

Area/Tooth Code/Surface	Date of Service	Procedure Description	Submitted Amount	Maximum Approved Fee	Contract Dentist Savings	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: DELTA DENTAL OF NEW MEXICO		PRODUCT: DELTA DENTAL PPO (POINT-OF-SERVICE)									
CLIENT/ID:	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
SUBCLIENT:	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
NETWORK:	PREMIER	DENTIST	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Total			[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

A. This section contains Subscriber and Patient identification information that can help you check on the status or question a Service in a Claim.

B. The Procedure Description explains the Services that you received.

C. Submitted Amount is the Billed Amount.

D. Amount Allowed reports our contracted fees for each Service.

E. If a Service is not completely covered by us, the Deductible is the amount applied to the Service.

F. Co-pay identifies the percentage the Plan covers for each Service.

G. Payment is the amount we paid to the Dental Provider for Services rendered.

H. Patient Payment is the amount you owe the Dental Provider.

F. To Whom Benefits Are Paid

1. DDNM agrees to make payments for Covered Services provided to you and your Enrolled Dependents as described in this Summary Plan Description and the Summary of Benefits.
2. DDNM 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. DDNM 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 DDNM 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.

DDNM 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. DDNM 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

DDNM is 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**. 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**. DDNM will do its 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.

VI. 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 SUMMARY PLAN DESCRIPTION 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:

1. 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.

2. 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.

3. Maximum Benefit Amount

DDNM 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, will cover the following Diagnostic Services with no waiting period:

a. One (1) clinical oral examination twice per Calendar 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:

- a. Bitewings are payable twice per Calendar Year 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 (5) 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 Calendar Year. Enrolled Persons with documented history of periodontal disease are eligible for two (2) additional periodontal cleanings per year.
 - b. Fluoride Treatment. Two (2) fluoride treatments per Calendar Year in a healthcare setting for children up to 19 years old.
- C. Molar Sealants. One (1) treatment of molar sealant per tooth every three (3) consecutive years as Medically Necessary and appropriate. Coverage is excluded where an occlusal restoration has been completed on the tooth. **Limitations on Diagnostic and Preventive Services**
1. Benefit for patient pre-diagnostic 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 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 as the 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. DDNM 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 three (3) 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 five (5) years for a Patient up to age nineteen (19).
16. Fixed unilateral, removable unilateral, and removable bilateral space maintainers are payable once per quadrant per five (5) years for a Patient up to age nineteen (19).
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 re-cementation, 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, re-cementation, 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

DDNM may pay for additional Benefits for a Patient with specified medical conditions. Delta Dental of New Mexico reserves 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 (e.g., 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 include 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

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 include 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, $\frac{3}{4}$ crowns, and veneers.
10. Posts and cores in addition to a crown are a Benefit only on endodontically treated teeth. In addition to the requirement for endodontic treatment, anterior teeth must have insufficient tooth structure to support a cast restoration. Fees are Not Billable to the patient when these requirements are not satisfied.
11. A separate fee for the re-cementation 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 re-cementation, 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. Initial prosthetic placement for congenitally missing teeth is not covered.
25. Benefits for porcelain crowns or porcelain supported prosthetics on posterior teeth are limited to premolars and maxillary first molars. On all other teeth, they are considered Optional Services and Benefits are limited to the equivalent metal crown or metal supported prosthetic Benefit.
26. Maxillofacial prosthetics and related services are not a Benefit.
27. Crowns, implants, prosthodontics, and all related services are not Benefits for patients under the age of sixteen.
28. Fees for full or partial dentures include any relines/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.
29. Tissue conditioning is not a Benefit more than twice per denture unit in a three-year period.

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. DDNM does not cover or reimburse for home-based or self-applied orthodontic treatments.

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 of 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.

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. 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.
2. 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.
3. 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.
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 is not covered.
7. Cosmetic surgery or procedures are not covered.
8. Prosthodontic services or any single procedure started before the Patient is covered under this Plan is not eligible for Benefits.
9. Prescribed drugs, pain medications, desensitizing medications, and therapeutic drugs 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. A separate fee for a consultation with a medical care professional is not billable to the Patient.
12. A separate fee for certified translation or sign language services is not billable to the Patient.
13. 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.
14. Orthodontic Services, or any Services related to an orthodontic treatment plan, are not covered unless stated otherwise in the Summary of Benefits.
15. Treatment of the temporomandibular joints (TMJ) is not a covered expense.
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, which 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. Occlusal orthotic devices are not a Benefit.
29. 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.
30. 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.
31. Home-based or self-applied orthodontic treatments are not a Benefit.
32. Sales tax is not a Benefit.
33. 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.
34. Services excluded by our policies and procedures, including but not limited to Processing Policies, are not a Benefit.
35. 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.
36. Services received due to an act of war or terrorism, declared or undeclared, are not a Covered Service.
37. Services that are not covered under this Plan are not a Benefit.

VII. 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, the administration of general anesthesia, or TMJ 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.

VIII. 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 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, or Experimental or Investigational.

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 or is Experimental or Investigational.
- 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 do not 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**



**** 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 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**, 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 **two 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 **five 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 do not 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 do not 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**



****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**, 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 **two 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 do not 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 do not 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

IX. 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.

X. 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.

XI. 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.

XII. 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

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, establishing premium and underwriting rules, evaluating a request for dental Benefit products, administering those products, 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**, or **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

XIII. 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 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 the third party admits liability. *See also*, [Section VII(E) and Section VIII(G)].

C. Right of Recovery Due to Fraud

If Delta Dental 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 New Mexico may recover that payment from Enrolled Persons. Delta Dental 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 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 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 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 New Mexico does not furnish Services, but only makes payment for Covered Services incurred by Enrolled Persons. Delta Dental 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 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 SPD 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 SPD 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 SPD or new coverage. No employee of Delta Dental of New Mexico may change this SPD by giving incomplete or incorrect information, or by contradicting the terms of this SPD. 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 SPD, 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.



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ATTACHMENT



SONM Group Requirements

The following information describes the specific requirements set by the State of New Mexico (“SONM” or “Group”) for Eligibility and Enrollment Requirements.

Please check with your SONM Human Resources Department, if you have any questions or need assistance.

Who is Eligible?

1. Employee Eligibility

- 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 stepchildren from a previous marriage, and neither the employee nor spouse has adopted them or obtained legal guardianship, the stepchildren 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 signed 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.