

GROUP DENTAL PLAN

for



COLORADO COLLEGE

1 8 7 4

GROUP NUMBER - 0284

EFFECTIVE - July 1, 1998

REVISED - July 1, 2002



DELTA DENTAL®

Delta Dental Plan of Colorado

SEE INSIDE FOR
GROUP I.D. CARDS

**Visit Delta's website at:
www.deltadentalco.com**

You can search for a dentist, download a claim form
or access other personal account information.



DELTA DENTAL®

Delta Dental Plan of Colorado

Stanford Place III

4582 South Ulster Street, Suite 800

Denver, CO 80237

(303)741-9300

Customer Service:

(303) 741-9305 or (800) 610-0201

INTRODUCTION

YOUR DENTAL PROGRAM

We are pleased to introduce you to your new dental program. This dental program, if used properly, will provide for you one of the finest health care benefits available anywhere.

ELIGIBILITY

All present and future eligible employees are classified as follows:

- Class 1: Active, Full-time Employees: All active full-time faculty, administrators, and support staff employees.
- Class 2: Active, Part-time Employees: All active adjunct faculty, part-time faculty, part-time administrators, and part-time support staff who are regularly scheduled to work a minimum of 1,000 hours per year, or 4 blocks or equivalent, of teaching per year.
- Class 3: Active, Special Senior Status Members: Any active employees who are appointed to Special Senior Status by the College President, who have at least 17 years of service, and are at least 59½ years of age.
- Class 4: Retirees who are at least 55 years of age.

These classes will be eligible for coverage as follows:

- Class 1: On the first day of the month following or coincident with date of hire.
- Class 2: On the first day of the month following or coincident with completion of one year of part-time service.
- Class 3: Immediately upon appointment to Class.
- Class 4: Minimum of 10 years of Service.

Your dependents who are covered, are your lawful spouse or domestic partner and your unmarried children less than nineteen (19) years of age or any unmarried children, nineteen (19) years of age but under twenty-four (24) years who attend an educational institution on a full-time basis and depend upon you for support. This includes any stepchild, foster child or legally adopted child who lives with the employee in a regular parent-child relationship. Children who do not live with the employee, but are directed by court order to be covered by the employee, are also eligible.

Dependent children who are unable to gain employment because of permanent physical or mental impairment that commenced **prior to** reaching age nineteen (19) will be continued as eligible dependents for dental benefits provided proof of such handicap or incapacity is submitted within thirty-one (31) days after it is requested by Delta. No one may be covered as a dependent and also as an employee, and if both parents are covered as employees, children may be covered as dependents of one employee only.

Dependents in active military service are not covered.

ENROLLMENT OF DEPENDENTS

- a. Eligible children may be added within thirty-one (31) days of birth or acquisition; children under age three (3) may be added on any anniversary until the anniversary coincident with or next following the date the dependent child turns three (3) years of age. If added after that date, the child will be considered a late enrollee.
- b. Any eligible dependents not enrolled as described above or who are enrolled and subsequently dropped from the plan will not be eligible to enroll at a later date except as a late enrollee.
- c. Any eligible dependents that suffer involuntary loss of coverage through another source will be allowed to enroll with satisfactory proof of coverage loss. Such dependents must be enrolled within thirty-one (31) days of loss of coverage.

LATE ENROLLEE

Employees or dependents who are not enrolled when they are initially eligible can enroll at any time but will be considered a "late enrollee". Any late enrollee must be continuously enrolled for a period of twelve (12) consecutive months before covered services other than diagnostic and preventive services become payable under the contract. The exception to this rule is an eligible employee or dependent who involuntarily loses coverage through another group insurance plan. Involuntary loss of coverage is defined as loss due to death, divorce, loss of job or termination of benefits by employer. Such employee or dependent will be allowed to enroll within thirty-one (31) days of the loss of coverage with satisfactory proof of coverage loss.

TERMINATION OF COVERAGE

Coverage of enrolled eligible employees will terminate on the earliest of the following:

- a. The last day of the month that eligibility is terminated in accordance with the eligibility rules of the Contract, unless the eligible employee elects continued coverage under the COBRA provisions.
- b. The last day of the month for which premium has been paid.
- c. The day the Master Contract is terminated.

Coverage for enrolled eligible dependents will terminate on the earliest of the following:

- a. The day the enrolled eligible employee's coverage under which they are covered terminates in accordance with the above.
- b. The last day of the month for which premium for dependent coverage has been paid.
- c. The last day of the month during which the enrolled eligible dependent ceases to be eligible in accordance with the eligibility rules of the Contract unless continued coverage is elected by or on behalf of any dependent under the COBRA provisions.

HOW TO USE THE DELTA DENTAL PLAN

You may visit any dentist of your choice. If your dentist is a participating member of Delta Dental Plan, the claim form for benefits will be filed by your dentist. The patient should complete the top or patient section of the claim form and sign the form to indicate that he/she authorizes release of the information to Delta.

If you are treated by a **DeltaPreferred Option (DPO)** Dentist, you will receive the highest benefits available on this plan. Delta makes payment directly to the dentist and sends an Explanation of Benefits to the employee indicating how much the dentist has been paid and the amount which the employee is responsible for paying. If there is an amount not chargeable to the patient, that is shown on the Explanation of Benefits as well. DeltaPreferred Option Dentists provide services at a reduced fee which means that your co-payment based on that fee will be less.

Both DeltaPreferred Option Dentists and DeltaPremier Participating Dentists have agreed to collect only the portion of your charges for which you are ultimately responsible (i.e., deductible and coinsurance). You will not be charged the entire fee at the time services are rendered unless the service you receive is not covered by your plan.

If you are treated by a **DeltaPremier Participating Dentist** locally or nationwide you will receive the benefits indicated for Premier Participating Dentists.

Should you elect to receive treatment from a dentist who has not enrolled with Delta as either a DPO or a Premier Participating Dentist (i.e., a **non-participating dentist**), you will be fully responsible for filing your claim and for payment to the dentist. You may obtain a claim form from your Human Resources/Personnel office or from Delta by calling the number on the back cover. Delta will reimburse you for the services of a non-participating dentist. You will be reimbursed on the basis of the lower level of benefits and the prevailing fees within his/her area of the country for the covered services you receive. By going to a non-participating dentist, you do risk additional out of pocket costs.

If you anticipate extensive dental services which would exceed \$400.00, your dentist should submit a treatment plan to Delta for review before any work is actually done. Predetermination of benefits allows both you and your dentist to know exactly what is covered and what your plan will pay. There is no additional charge for having a predetermination done.

Delta will not be obligated to pay claims submitted more than twelve (12) months after the date the service was provided.

If the patient or employee encounters any problems relative to fee differences, possible excessive charges or refusal on the part of a DPO or Premier Participating Dentist to cooperate with the program, the employee should write a detailed letter explaining the situation to Delta Dental Plan of Colorado. Prompt action can be expected if all the information is submitted in writing.

BENEFIT PAYMENT

PREFERRED OPTION DENTIST

Patients who choose a DPO Dentist receive the highest level of benefits. A Preferred Option Dentist is a dentist who is licensed to practice, has met the criteria for the DeltaPreferred Option program and is also a DeltaPremier Participating Dentist who has signed a special agreement with Delta to participate in the DPO program.

PREMIER PARTICIPATING DENTIST

Premier Participating Dentist means a dentist who is licensed to practice and who has signed an agreement with Delta Dental Plan. Over 100,000 dentists, or 2 out of 3 dentists nationwide are Premier Participating Dentists. Under the terms of a signed agreement with Delta, Premier Participating Dentists agree to render dental care to eligible patients according to requirements established by the Board of Trustees of Delta Dental Plan. Premier Participating Dentists agree to:

- Submit claim forms for their patients.
- Accept direct payment from Delta. They may charge the patient only for the portion of the treatment that is not covered by the plan, i.e., the deductible and/or any coinsurance.
- File a listing of their usual fees, on a confidential basis. Payment will be based upon the Premier Participating dentist's usual, customary and reasonable fee as filed with and accepted by Delta.

NON-PARTICIPATING DENTIST

Non-participating dentists have not signed participating agreements or filed fees. If a non-participating dentist is chosen, the patient may have additional costs out of pocket. The benefit is based on the prevailing fees of Premier Participating Dentists. The patient will also be fully responsible for the dentist's entire fee and for filing the claim with Delta.

BENEFIT PERCENTAGES

DIAGNOSTIC AND PREVENTIVE SERVICES

- 100% of a Preferred Option Dentist's allowable fee or
- 80% of a Premier Participating Dentist's usual, customary and reasonable fee.
- 80% of the usual, customary and reasonable fees allowable by Delta for a Non-Participating Dentist.

BASIC SERVICES

- 80% of a Preferred Option Dentist's allowable fee or
- 50% of a Premier Participating Dentist's usual, customary and reasonable fee.
- 50% of the usual, customary and reasonable fees allowable by Delta for a Non-Participating Dentist.

MAJOR SERVICES

- 50% of a Preferred Option Dentist's allowable fee or
- 50% of a Premier Participating Dentist's usual, customary and reasonable fee.
- 50% of the usual, customary and reasonable fees allowable by Delta for a non-Participating Dentist.

ORTHODONTIC SERVICES

50% of a Preferred Option Dentist's allowable fee or

50% of a Premier Participating Dentist's usual, customary and reasonable fee.

50% of the usual, customary and reasonable fees allowable by Delta for a Non-Participating Dentist.

MAXIMUM BENEFIT

Each eligible employee and each eligible dependent may receive up to \$1,250.00 of covered dental benefits in each calendar year for Diagnostic, Preventive, Basic and Major services. Each eligible dependent child may receive up to \$1,600.00 per lifetime for Orthodontic services.

DEDUCTIBLE

Services received from a DPO dentist:

The patient is responsible for the first \$25.00 each calendar year. The deductible does not apply to Diagnostic, Preventive and Orthodontic services. The \$25.00 annual deductible is limited to three (3) deductibles per family for a total of \$75.00.

Services received from a Non-DPO dentist:

The patient is responsible for the first \$50.00 each calendar year. The deductible applies to all services except Orthodontic services. The \$50.00 annual deductible is limited to three (3) deductibles per family for a total of \$150.00.

COVERED DENTAL SERVICES

This booklet is not a contract. The summary information in this booklet is intended to describe in general terms the main features of the program and does not constitute a contract. The specific terms and conditions governing the coverage are set forth in the Contract between Delta and your group and constitutes the basis on which claims will be paid.

A listing of Dental Terminology is located at the end of this brochure.

I. DIAGNOSTIC, PREVENTIVE AND ADJUNCTIVE SERVICES

Diagnostic - Provides the necessary procedures to assist the dentist in evaluating the conditions existing and the dental care required as provided for in the Contract. Covered Diagnostic services include:

Oral Examination - to include initial, periodic or emergency

Dental X-Rays - to include complete (full mouth) series, single x-rays, or bitewings

Preventive - Provides the necessary procedures or techniques to prevent the occurrence of dental abnormalities or disease as provided for in the Contract. Covered Preventive services include:

Dental Cleaning - to include removal of all deposits and/or stains, and polishing as a single complete service.

Adjunctive - Services including emergency treatment performed as a temporary measure to relieve pain as provided for in the Contract.

LIMITATIONS ON DIAGNOSTIC, PREVENTIVE AND ADJUNCTIVE BENEFITS

- a. Complete mouth x-rays are a benefit only once in sixty (60) months, unless a special need exists.
- b. Bitewing x-rays are a benefit only once in a twelve (12) month period and are not a benefit in addition to a complete series.
- c. Cleanings and oral examinations are a benefit only twice in a twelve (12) month period.
- d. Topical fluoride application is a benefit only to children through age fifteen (15), and is a benefit only once in a twelve (12) month period.
- e. Benefits for examinations will not be paid when performed in conjunction with any covered Adjunctive service.
- f. Benefits for covered Diagnostic services may be allowed toward the cost of Special Diagnostic services or techniques and the patient shall be responsible for the portion of the dentist's fee in excess of the Delta allowance.
- g. Space maintainer is a benefit only for premature loss of deciduous (baby) teeth for children through age thirteen (13).
- h. Sealant benefits include the application of sealants only to permanent molar teeth with the occlusal surfaces intact, no caries (decay), and with no restorations.
- i. Separate benefits shall not be paid for any preparation or conditioning of the tooth or any other procedure associated with sealant application.
- j. Sealant benefits do not include any repair or replacement of a sealant on any tooth within thirty-six (36) months of its application. Such repair or replacement is considered included in the fee for the initial placement of the sealant.
- k. Sealants are a benefit only for eligible dependent children through the age of fourteen (14).

II. BASIC SERVICES

Restorative - Provides the necessary procedures to restore the teeth other than Special Restorative. Covered Basic Restorative services include amalgam, silicate and resin restorations.

Endodontics - Includes the necessary procedures for pulpal and root canal therapy as provided for in the Contract.

Oral Surgery - Extractions and certain other surgical services and associated covered anesthesia as provided for in the Contract.

Periodontics - Services for treatment of gums and bone supporting teeth as provided for in the Contract.

LIMITATIONS ON BASIC SERVICES

- a. Benefits for the same covered Basic Restorative service shall not be provided more than once in any twelve (12) month period.
- b. Allowance for amalgam on posterior (back) teeth or intraorally cured (placed and hardened completely in the mouth) resin or plastic restorations (fillings) on anterior (front) teeth may be made toward the cost of more expensive procedures or materials selected, and the patient shall be responsible for the portion of the dentist's fee in excess of the Delta allowance.
- c. Covered surgical periodontic services are a benefit only once in a thirty-six (36) month period and covered adjunctive periodontic services are a benefit only once in a twenty-four (24) month period, unless evidence of special need is provided to Delta.
- d. Pulpotomy, Pulpectomy is a benefit only for deciduous (baby) teeth.
- e. Benefits for non surgical periodontal procedures which include any component of prophylaxis are limited to those provided under the limitation of Diagnostic and Preventive services.
- f. No benefit shall be provided for any procedures performed on teeth retained in relation to an overdenture.

Late Enrollees will be required to be continuously enrolled in the dental plan for twelve (12) months before becoming eligible for Basic services benefits.

III. MAJOR SERVICES

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

LIMITATIONS ON SPECIAL RESTORATIVE BENEFITS

- a. If more than one restoration is used to restore a tooth, benefits will not exceed the covered amount for a single covered service.
- b. Special Restorative services are a benefit only once in sixty (60) months for procedures involving the same teeth.
- c. Special Restorative services are not a benefit for children under age twelve (12).
- d. No benefit shall be provided for any procedures performed on teeth retained in relation to an overdenture.

Prosthodontics - Services for construction or repair of fixed bridges, removable partial and complete dentures to replace completely extracted or missing natural permanent teeth as provided for in the Contract.

LIMITATIONS ON PROSTHODONTIC BENEFITS

- a. Replacement of an existing prosthetic appliance is a benefit only once in sixty (60) months and only if the appliance is unsatisfactory and cannot be made satisfactory.
- b. A covered prosthodontic appliance is a benefit only after sixty (60) months have elapsed for any payment of covered Special Restorative benefit for the same tooth.

- c. Delta will pay the allowed percentage of the dentist's fee for a standard cast base metal and/or acrylic partial denture or a standard complete denture, up to a maximum fee allowance for a standard denture. The patient is responsible for the portion of the dentist's fee in excess of the Delta allowance.
- d. Removable temporary partial dentures are a benefit only when anterior teeth are missing. An allowance limited to the covered amount for a removable appliance may be made toward the cost of the other procedures performed. The patient is responsible for the portion of the dentist's fee in excess of the Delta allowance.
- e. Benefits based on the cost of a covered complete or removable partial denture may be allowed toward the cost of appliances constructed in association with implants. If benefit is allowed for such an appliance, benefits will not be allowed for any replacement within sixty (60) months thereafter.
- f. Fixed bridges and/or cast metal framework partial dentures are not a benefit for persons under age sixteen (16).
- g. Fixed and removable prosthodontic appliances in the same arch are not a benefit except in cases of special need as determined by Delta in its sole and absolute discretion. Any allowance made will be limited to the cost of a removable appliance.
- h. Overdenture appliance benefits will be limited to the allowance for a standard appliance.
- i. Benefits for reline or rebase of a prosthodontic appliance will be made only once in any thirty-six (36) month period. Reline or rebase of a prosthodontic appliance at the time of insertion and/or within six (6) months following insertion is considered a component of the appliance and a separate payment will not be made.

Late Enrollees will be required to be continuously enrolled in the dental plan for twelve (12) months before becoming eligible for Major services .

IV. ORTHODONTIC SERVICES

The procedures associated with oral surgery or appliance therapy for movement of and post-treatment retention of improperly aligned teeth and/or jaws including any related diagnostic, preventive or interceptive services except extraction of teeth. **Only dependent children under age nineteen (19) are eligible for Orthodontic benefits.**

LIMITATIONS ON ORTHODONTIC BENEFITS

- a. Replacement or repair of appliances is not a benefit.
- b. Orthodontic care provided in the treatment of periodontal cases or cases involving treatment or repositioning of the temporomandibular joint or related conditions is not a covered service.
- c. The obligation of Delta to make periodic payments for an Orthodontic treatment plan shall cease upon termination of treatment for any reason prior to completion of the case.

- d. The obligation of Delta to make periodic payments for an Orthodontic treatment plan begun prior to the eligibility date of the patient shall commence with the first payment due following the patient's eligibility date. The Orthodontic lifetime maximum amount payable will apply fully to this and subsequent payments.
- e. The obligation of Delta to make periodic payments for an Orthodontic treatment plan shall cease upon termination of the covered person's eligibility.
- f. Delta's obligation to make periodic payments for Orthodontics shall terminate on the date the eligible dependent child(ren) reaches age nineteen (19).
- g. Extended coverage provisions do not apply to Orthodontic services.

Late Enrollees will be required to be continuously enrolled in the dental plan for twelve (12) months before becoming eligible for Orthodontic services benefits.

GENERAL LIMITATIONS - ALL SERVICES

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

EXCLUSIONS

THE FOLLOWING SERVICES ARE NOT BENEFITS:

- a. Services for injuries or conditions which are compensable under Workers' Compensation or employers' liability laws, or services which are provided to the eligible person by any federal or state government agency or are provided without cost to the eligible person by any municipality, county or other political sub-division, or any services for which the eligible person would have no obligation to pay in absence of this coverage, except as such exclusion may be prohibited by law, such as Medicaid.

- b. Any covered service started during any period when the person was not eligible for such service under the Contract.
- c. Services for treatment of congenital (present at birth) or developmental (following birth) malformations, except intraoral dental services for treatment of a condition which is related to or developed as a result of cleft lip and/or cleft palate, unless otherwise included as a covered service of the Contract.
- d. Services for cosmetic reasons.
- e. Services for restoring tooth structure lost from wear, chemical erosion or for any services related to protecting, altering, correcting, stabilizing, rebuilding or maintaining teeth due to improper alignment, occlusion or contour or for splinting or stabilization of teeth.
- f. Habit appliances, night guards, occlusal guards, athletic mouth guards and gnathological (jaw function) services, bite registration or analysis, or any related services (except as covered under this plan).
- g. Pre-medication, analgesia, hypnosis or any other patient management services.
- h. Charges for prescription drugs.
- i. Experimental procedures, or any procedures other than those covered services for which the prognosis is good. Any procedures done in anticipation of future need (except covered preventive services).
- j. Hospital costs and any additional fees charged by the dentist or hospital for hospital services, visits, or charges for use of any facility.
- k. Anesthesia other than general anesthesia, intravenous sedation or analgesia administered in connection with covered oral surgery services as provided for in the Contract.
- l. Extraoral grafts (grafting of tissues or other substances from outside the mouth to or into oral tissues), augmentations or implants and/or any associated appliances. Removal of implants or any services associated therewith.
- m. Services for the treatment of any disturbances of the temporomandibular joint (jaw joint), facial pain, or any related conditions, including any related diagnostic, preventive or interceptive services. Myofunctional therapy or speech therapy.
- n. Services not performed in accordance with the laws of the State of Colorado, services performed by any person other than a person authorized by license to perform such services, or services performed to treat any condition, other than an oral or dental disease, malformation, abnormality or condition.
- o. Oral hygiene instructions or dietary instructions.
- p. Completion of forms, providing diagnostic information or records, or duplication of x-rays or other records.
- q. Replacement of lost, stolen or damaged appliances.
- r. Preparation for placement or replacement, removal or repair, or any other procedure related in any way to any procedure or service not included in covered services. Any services not specifically included as covered.
- s. Services for which payment is prohibited by any law of the jurisdiction in which the eligible person resides at the time the expenses are incurred.
- t. Services for which charges would not have been made if this coverage had not existed, except for services as provided under Medicaid.

COORDINATION OF BENEFITS

- a. If an eligible person is entitled to coverage under two or more plans, then the benefits of the Contract shall be coordinated with other plan benefits.

“PLAN” means any plan providing dental care benefits under group, blanket or franchise coverage; or service type plans or other group pre-paid plans; or coverage under any governmental plan or required by law; or “No-Fault” motor vehicle insurance.

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

1. The policy or program covering the patient as an employee shall be primary over the policy or program covering the patient as a dependent;
2. For dependent children's expenses the order of benefit determination shall be as follows:

- a. The policy of the parent whose birthday (excluding year of birth) occurs earlier in a year shall be primary, or;
- b. If the parents are separated or divorced, the policy of the parent who is ordered by court decree to take financial responsibility for dental expenses shall be primary, or;
- c. The policy of the parent with custody is primary and if said parent has remarried, the step-parent's plan is secondary and the plan of the parent without custody is tertiary.

3. If the above rules do not establish an order of benefit determination, the plan that has covered the person for the longer period of time shall be primary with the following exception:

The plan covering the person as a laid-off or retired employee or dependent of such person, shall be determined after the benefits of any other plan covering the person or employee.

4. Any group plan that does not contain a coordination of benefits provision is automatically primary.

If this plan is primary as provided above, this plan shall provide benefits without regard to benefits provided by any other plan. If this plan is secondary, this plan will provide benefits which together with the other plan(s) will not exceed 100% of the covered dental expense or this plan's maximum benefit, whichever is less.

WHEN TO USE YOUR DENTAL CARE PLAN

Routine dental care is the best way to maintain your oral health. Start at your earliest convenience and repeat your check-ups at least annually.

INTERNAL APPEAL OF CLAIMS

Questions concerning the action taken on a claim can be directed to the Customer Service Department for clarification. If the explanation is not acceptable, you may appeal the determination by writing to the Dental Director of Delta Dental within one hundred and eighty (180) days after receiving a written denial. Any written communication should include documents or records in support of your claim. Delta may submit the matter to the Executive Committee of the Board of Trustees for review.

EXTERNAL APPEAL OF CLAIMS (only available on qualified claims)

In addition to the Internal Appeal procedures, covered persons have certain rights under Colorado Division of Insurance Regulation 4-2-21. You may request an Independent External Review of a claim when the above Internal Appeal procedures result in a final denial **AND** that final denial is based on one of the following reasons:

- medical necessity;
- effectiveness;
- efficiency;
- experimental; or
- investigational.

When a claim qualifies for External Review, Delta will mail you a notice that explains your right to request an Independent External Review of the denied claim. In addition to the notice, you will receive the required forms for submitting your request.

EXTENDED COVERAGE

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

NOTICE OF RIGHT TO COBRA COVERAGE

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended by Congress in 1986 and 1989 and further amended by the Health Insurance Portability and Accountability Act of 1996, eligible persons who would lose coverage under their employer sponsored group health plan (which includes dental plan coverage) due to certain "Qualifying Events" are entitled to elect continued coverage at their own expense.

Eligible employees and dependents losing coverage due to either of the following Qualifying Events may elect to continue coverage for eighteen (18) months following the month in which the event occurs:

- An eligible employee's termination of employment (other than for gross misconduct); or
- An eligible employee's reduction in work hours to less than any minimum required to be eligible under the contract.

Any eligible employee or dependent who is eligible for COBRA continuation coverage who is disabled and determined to be eligible for Social Security disability benefits at the time of termination of employment or reduction of hours may elect to extend coverage for themselves and their dependents for up to an additional eleven (11) months following the eighteen (18) month extension allowed for the initial Qualifying Event. This right also applies if the eligible employee or dependent is totally and permanently disabled within sixty (60) days after termination of employment or reduction of hours. The employee or dependent must notify the employer in writing of the Social Security disability determination within sixty (60) days of the date it is issued, and before the end of the initial eighteen (18) month COBRA coverage period. The employee or dependent must also notify the employer within thirty (30) days of the date of any final determination by the Social Security Administration that the employee or dependent is no longer disabled.

Eligible dependents losing coverage due to any of the following Qualifying Events may elect to continue coverage for thirty-six (36) months following the month in which the event occurs:

- An eligible employee's death;
- A divorce or legal separation from an eligible employee;
- A dependent child's ceasing to qualify as an eligible dependent under this Program; or
- An eligible employee's entitlement to Medicare benefits.

Anyone who has elected continued coverage and becomes covered under another plan may continue coverage if the new plan contains a pre-existing condition limitation. Coverage will be continued until the earlier of: the expiration of the pre-existing condition limitation of the new plan or the expiration of the original continuation period. The new plan must count the months for which you have had prior creditable coverage for the pre-existing condition. It is the employee's or dependent's responsibility to consult with their new plan administrator to determine if this provision applies in their case.

If a COBRA enrollee becomes entitled to Medicare before the expiration of eighteen (18) months then any of his dependents will be entitled to continuation of coverage for a total of thirty-six (36) months from the date of the original Qualifying Event.

Anyone who is entitled to elect continued coverage based on more than one Qualifying Event shall be limited to continued coverage for a total of thirty-six (36) months following the date of the first Qualifying Event.

You or your dependent must notify your employer within sixty (60) days after a divorce or legal separation, or if a dependent child loses eligibility. Otherwise, the option of continued coverage based on one of these events will be lost.

Once aware of a Qualifying Event, the employer will notify affected persons about their right to elect continued coverage. This notice will include the amount of monthly fees the employer will charge them for continued coverage as permitted by law. Persons desiring continued coverage must advise the employer within sixty (60) days after receiving such notice, or within sixty (60) days after losing coverage due to the Qualifying Event, whichever is later. You or your dependent will then have forty-five (45) days to pay the initial installment of fees which shall include fees for all months since the Qualifying Event.

Continued coverage shall be the same as for eligible employees and their dependents. If coverage is modified for eligible employees and their dependents, it shall also be modified in the same manner for persons with continued coverage and an appropriate adjustment in fees may be made by the employer.

After COBRA coverage begins, the COBRA enrollee may add a newborn child, an adopted child or a child who has been placed with the employee for adoption and for whom the employee has financial responsibility. The COBRA enrollee must notify the employer in writing within thirty-one (31) days of the birth or placement in order to add the child to the COBRA coverage. A child born, adopted or placed for adoption and enrolled as indicated will have the same COBRA rights as any other dependents covered by the plan before the event that triggered COBRA coverage.

A person's continued coverage elected under the Contract will terminate at the end of the month in which any of the following events first occurs:

1. The allowable number of months of continued coverage (i.e. 18, 29 or 36 months) expires.
2. The Contract terminates.
3. Fees are not paid for the person as required.
4. The person becomes enrolled for dental benefits under another group dental plan (as an employee or otherwise).
5. The person becomes entitled to Medicare.

Once continued coverage terminates, it cannot be reinstated.

COLORADO COLLEGE RIGHTS AND PROTECTIONS UNDER ERISA

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about the plan, you should contact the plan administrator. If you have any questions about this statement or about the rights under ERISA, you should contact the nearest area office of the U.S. Labor-Management Services Administration, Department of Labor.

FACTS YOU SHOULD KNOW ABOUT GROUP NO. 0284

1. Name of Plan:
THE COLORADO COLLEGE MEDICAL AND DENTAL PLAN
2. Name and Address of Policyholders::
THE COLORADO COLLEGE
14 E. CACHE LA POUFRE
COLORADO SPRINGS, COLORADO 80903
3. Employer Identification No. (E.I.N.) assigned for this Plan by IRS:
84-0402510
4. Type of Plan: Welfare plan provided for purpose of providing dental insurance coverage
Plan No. 501
5. Type of Administration:
CLAIMS PAID BY DELTA DENTAL
6. Name and Address of Plan Administrator:
THE COLORADO COLLEGE
14 E. CACHE LA POUFRE
COLORADO SPRINGS, COLORADO 80903
7. The name and address of the person designated as agent for service of legal process and address at which process may be served:
DIRECTOR OF HUMAN RESOURCES
THE COLORADO COLLEGE
14 E. CACHE LA POUFRE
COLORADO SPRINGS, COLORADO 80903
8. Sources of Contributions: EMPLOYER AND EMPLOYEE
9. Plan Anniversary (Plan Fiscal Year):
July 1 - June 30
10. Claims Disputes:
If you have a claim which has been partially or wholly denied, and you wish to question the claim decision, contact:

Delta Dental Plan of Colorado
4582 S. Ulster Street, Ste 800
Denver, Colorado 80237
(303) 741-9300
(800) 233-0860
Customer Relations
(303) 741-9305
(800) 610-0201

DENTAL TERMINOLOGY

Amalgam: A mixture of two or more metals in combination with mercury used as a restorative material.

Anesthesia: The loss of sensation or feeling with or without loss of consciousness.

Anterior: Front. The first six teeth in the upper and lower jaws.

Bitewing: A diagnostic x-ray film; generally used to detect the presence of dental decay.

Bridge: (Fixed) An appliance replacing missing or extracted natural teeth, supported and held by attachments to restored (abutment) teeth and usually not removable.

Cast: Reproduction of the form of all or part of the dental arch (teeth and tissues) made from plaster or stone.

Crown: The portion of a natural tooth covered by enamel. A dental prostheses restoring the function and esthetics of part or whole of the coronal portion of the natural tooth; usually composed of gold, porcelain, or acrylic resin.

Denture: An artificial substitute for missing natural teeth, either being complete (full) or partial.

Denture Reline: To resurface the tissue-borne areas of a denture with a new material.

Endodontics: A specialty area of dentistry concerned with diagnosis and treatment of diseases of the pulp chamber and canals.

Extraction: The separation and surgical removal of a tooth from its natural state.

Fluoride Treatment: A topical application of a solution of a fluoride to the teeth to protect against decay.

Impacted Tooth: Condition in which the unerupted or partially erupted tooth is positioned against another tooth, bone or soft tissue, thereby preventing complete eruption of the tooth.

Implantation: An insert into bone to support a crown or crowns; a partial denture or complete denture.

Inlay: A filling made outside a tooth, inserted in one piece and retained by aid of cement.

Oral Hygiene Instruction: Instruction on proper care of teeth.

Palliative: Action that relieves pain but is not curative.

Panorex: X-ray film that shows the curve of each dental arch and all the teeth therein; full mouth x-ray.

Partial Denture: An artificial device which replaces one or more but less than all of the natural teeth and associated structures that are supported by the teeth, being either removable or fixed.

Periodontics: The study and treatment of the gingival tissues; the tissues supporting the teeth.

Prophylaxis: A procedure of removing plaque, calculus and stains from tooth surfaces by scaling and polishing techniques; cleaning.

Rebase: A process of refitting a denture by replacement of the denture base material.

Reline: To resurface the tissue side of a denture with new base material to make it fit more accurately.

Resin: Organic substances that may be solid or semi-solid in form. Resins are used as a filling material and are named according to their chemical composition, physical structure and means of activation or curing.

Restoration: The term applied to the end result of repairing and restoring or reforming the shape, form, and function of part or all of a tooth.

Root Canal Therapy: Treatment of a tooth having a damaged pulp, usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with insert sealing material.

Sealants: Protective covering applied to the occlusal surfaces of permanent bicuspid and molars to prevent decay in children's teeth.

Space Maintainer: A fixed or removable appliance designed to preserve the space created by the premature loss of a tooth.

Temporomandibular Joint: The connecting hinge mechanism between the mandible (lower jaw) and the base of the skull (temporal bone).

Veneer: A layer of tooth colored material, usually porcelain or acrylic resin, that is attached to the surface of a crown or pontic by direct fusion, cementation, or mechanical retention.

**Visit Delta's website at:
www.deltadentalco.com**

You can search for a dentist, download a claim form
or access other personal account information.



Stanford Place III
4582 South Ulster Street, Suite 800
Denver, CO 80237
(303)741-9300
Customer Service:
(303) 741-9305 or (800) 610-0201