Dental Plan General Information

Plan Description

CSU offers two dental plans for employees to choose from: **Delta Dental Basic** and **Delta Dental Plus.** Both plans are self-insured and administered, including claims processing, by Delta Dental of Colorado.

Following is a Summary of the Dental Benefits which outlines the specific benefits of each plan.

Enrollment/Changes

Refer to Enrollment and Changes in the Administrative Provisions section.

Coverage

Dental coverage is not required. Please review the following Summary of Dental Benefits to determine which plan, if any, is best for you and your family.

Premiums

Refer to the Premium Summary section for rates.

Termination of Coverage

Refer to Termination of Coverage in the Administrative Provisions section for eligibility and rights to continue insurance.

Delta Dental on the Web
(Subscriber Connection
www.deltadentalco.com)

- Print ID Card
- Find a Dentist
- Check on Claim Status
- View Benefits
- Print Explanation of Benefits (EOB)

Claims Payments

For both dental plans, claims must be submitted within 12 months from the date of service. If submitted after 12 months, the plan will not make payment.

Dental Providers

You may obtain care from any licensed dentist. Neither dental plan requires the use of network dental providers. The Delta Dental Basic plan does not have an associated network. The Delta Dental Plus Plan has two networks (PPO and Premier). You will receive the best benefits by choosing a PPO dentist.

Coordination of Benefits

Delta Dental Basic

This dental reimbursement plan is always considered the secondary payer when a covered employee or dependent is also covered by another dental insurance plan.

Payments will only be processed after a determination has been made by the other dental plan. This Plan will provide Benefits, which together with the other Plan will not exceed 100% of the allowable expenses.

Delta Dental Plus

When employees and/or dependents are covered by this plan and another dental plan, coordination of benefits will be administered in the following manner. For children covered as dependents on this plan and as dependents on a spouse, domestic partner or a civil union partner's plan, the plan of the individual whose birthday falls first in the calendar year will be the primary payer. In the case of spouses, domestic partners or civil union partner's plan where coverage is other than as a dependent will be the primary payer.

If this plan is Secondary, this plan will provide Benefits which together with the other plan will not exceed 100% of the allowable expense of this plan's maximum benefit.

Note: Please refer to the official plan document for Coordination of Benefit rules for custody arrangements.

Pre-Determination of Benefits

Pre-determination of benefits is recommended for any expensive dental services. The typical guideline for obtaining a predetermination of benefits is approximately $400. This will allow you to determine in advance whether a proposed service is covered under the plan and, if covered, the extent of any deductibles and other out of pocket expenses.

Health Care Flexible Spending Accounts

Many unreimbursed dental expenses are considered eligible expenses for a Flexible Spending Account (FSA). Please refer to the FSA section for details.

DELTA DENTAL

Delta Dental of Colorado

Group Numbers
9709—Delta Dental Basic
9684—Delta Dental Plus

(800) 610-0201

The following is a summary of the coverage available through the CSU dental plans and is not to be construed as the official plan document which covers claims administration. Please contact Delta Dental of Colorado for dental coverage inquiries.

Delta Dental Basic

Plan Description

This is a Direct Reimbursement Plan rather than dental insurance in which benefits are payable according to the dentist's billed charges. There is no provider network associated with this plan. There is no deductible on this plan.

Plan Coverage

Covered expenses will be reimbursed at the following levels:

- 100% for the first $100; plus
- 50% of the next $1,400 for **each covered member** per calendar year.
- Maximum benefit is $800 for each covered member per calendar year.

Any expense other than those specifically excluded below, which is incurred by you and/or your enrolled dependents for services, supplies, medication, or appliances provided by or at the direction of a dentist is covered. If you and/or your covered dependents are enrolled under any other dental insurance plan, this plan will only pay after a determination has been made by your other dental insurance plan.

This plan reimburses for covered services regardless of the frequency of service and without applying Maximum Plan Allowance guidelines, up to the plan's maximum benefit.

Providers

Freedom of choice – as long as the provider is a licensed dentist. Dental benefits under the Delta Dental Basic Plan (a dental reimbursement plan) are not subject to any contractual arrangements between Delta Dental and the dental providers limiting the amount charged. Dental providers will charge their usual fees to members. There is no dental network associated with this plan.

Exclusions (what this plan does not cover)

- Orthodontia
- Jaw joint problems (generally known as TMJ)
- Any expenses payable by other dental plans under which you or your dependents are covered.

Claims Payments

Claim payments for the Delta Dental Basic Plan will be made direct to the member even if the dentist accepts assignment of benefits. You will be responsible for payment to the dentist. If your dentist will not submit the claim for you, you will need to complete a claim form and submit it to Delta Dental of Colorado. Claim forms are available at www.deltadentalco.com and www.hrs.colostate.edu/benefits/fap-insplans-ancillary.html

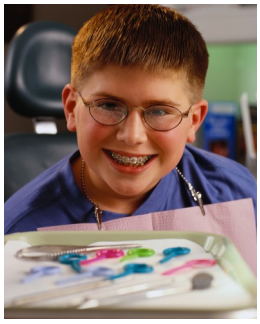
A separate claim form must be submitted for each member. Claims must be submitted within 12 months from the date of service or no payment will be made from the plan.

Claims Address
P.O. Box 173803
Denver, CO 80217-3803

Delta Dental Plus

Plan Description

This is a dental insurance plan which allows for varying levels of benefit payments depending upon the type of service provided by your dentist. If you or enrolled dependents are also covered under another dental plan, the Plan's coordination of benefits rules will apply.



Plan Coverage

Covered expenses will be reimbursed at the following levels after applicable deductibles.

Deductible

- The annual deductible is $50 per person or a maximum of 2 deductibles per family—$100.
- The deductible does not apply to Preventive or Orthodontic services.

Plan Maximums

- Preventive and Diagnostic services do not apply to the annual maximum, making your coverage last longer each year.

- Basic and Major services.
  - ◊ **$1,750—Annual maximum; per member per calendar year** (excludes any orthodontic services)
- Orthodontic Treatment and Appliances
  - ◊ **$1,800—Lifetime maximum** (excludes preventive and diagnostic, basic and major services)

Providers

Freedom of choice – You may use any licensed dentist. Maximum savings will be received when accessing care from a Delta Dental PPO Dentist.

Preventive and Diagnostic Dental Services—100% of Plan Allowable (no deductible)

- Routine oral examinations *(2 times per calendar year)*
- Routine cleanings (excludes periodontal.) *(2 times per calendar year)*
- Sealants on the occlusal surface of a permanent posterior tooth for dependent children. *(every 3 years until age 16)*
- Fluoride treatments for children . *(2 times per calendar year until age 14)*
- X-rays (in relation to preventive or diagnostic services only)
  - o *Bitewing x-ray series (2 times per calendar year)*
  - o *Full mouth/Complete Set (every 2 years)*
- Emergency palliative treatment for pain
- Space maintainers for covered Dependent Children until age 16 to replace primary teeth.

Basic Dental Services—80% of Plan Allowable (after deductible)

- Fillings, other than gold.
- Root canals. (including non-surgical endodontic treatment)
- Oral Surgery.
  - o Oral surgery is limited to tooth removal or preparation of the mouth for dentures and removal of tooth generated cysts.
- Administration of injectable antibiotic drugs.
- Recementing bridges, crowns or inlays.
- Periodontics. (gum treatments)
- Including scaling and root planning. *(four quadrants in any 24 month period)*
- Periodontal Cleanings. (2 in 12 months)
- Non surgical services.
- General or intravenous anesthesia for oral surgery procedures or upon demonstration of dental necessity.

Major Dental Services—60% of Plan Allowable (after deductible)

- Crown, Inlays and Onlays
- Periodontic services. (surgical)
- Bridges (installation and repairs)
- Dentures (relining, rebasing and attachment points)
- Implants (non cosmetic)

Orthodontia—50% of Plan Allowance (no deductible)

- 50% of eligible charges up to a $1,800 lifetime maximum

Covered orthodontic procedures include:

- Moving teeth into proper alignment, position and occlusion
- Preliminary study, including x-rays, diagnostic casts, treatment plan and active treatment
- Post-treatment appliances (retainers); doesn't include lost or broken appliances
- For an Orthodontic treatment plan started prior to the eligibility date of the patient, Delta Dental will begin periodic payments with the first payment due following the patient eligibility date. The maximum benefit will be determined based upon the prior payment records.

Delta Dental Plus Percent of Covered Expenses	
Preventive and Diagnostic Services	100%
Basic Dental Services	80%
Major Dental Services	60%
Orthodontia	50%

EXCLUSIONS

The following Services are not Benefits:

a) Services for injuries or conditions which are compensable under Worker's Compensation or employer's liability laws, or Services which are provided to the Covered Person by any federal or state government agency or are provided without cost to the Covered Person by any municipality, county or other political subdivision, or any Services for which the Covered Person would have no obligation to pay in absence of this coverage, except as such exclusion may be prohibited by law.

b) Any Covered Service Started when the person was not eligible for such Service under this Contract.

c) Services for treatment of congenital (present at birth) or developmental (following birth) malformations, except intraoral dental.

d) 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.

e) Services for cosmetic reasons.
f) Services related to protecting, altering, correcting, stabilizing, rebuilding or maintaining teeth due to improper alignment, occlusion or contour.
g) Services related to periodontal stabilization of teeth.
h) Habit appliances, night guards, occlusal guards, athletic mouth guards and gnathological (jaw function) Services, bite registration or analysis, or any related Services.
i) Charges for prescription drugs.
j) Dental treatment which is experimental or investigational in nature and not yet approved by the American Dental Association.
k) Any procedures done in anticipation of future need (except Covered Preventive Services).
l) Hospital costs and any additional fees charged by the Dentist or hospital for hospital services or visits, or charges for use of any facility.
m) Orthodontic Services including any related diagnostic, preventive or interceptive Services (surgical and other treatment of malalignment of teeth and/or jaws), unless shown as covered on the Summary of Dental Plan Benefits.
n) Myofunctional therapy or speech therapy.
o) Services for the treatment of any disturbances of the temporomandibular joint (TMJ), facial pain, or any related conditions, including any related diagnostic, preventive or interceptive Services.
p) Services not performed in accordance with the laws of the State in which Services are rendered, 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.
q) Oral hygiene instructions or dietary instructions.
r) Completion of forms, providing diagnostic information or records, or duplication of x-rays or other records.
s) Replacement of lost, stolen or damaged appliances.
t) Repair of appliances altered by someone other than a Dentist.
u) Any Services including any associated Services or procedures not specifically included in Covered Services.
v) Services for which charges would not have been made if this coverage had not existed, except for Services as provided under Medicaid.
w) Missed appointment charges.
x) Preventive control programs, including home care items.
y) Plaque control programs.

Claim Payments

Claims under the Delta Dental Plus plan will be processed according to Delta Dental's processing standards and contractual arrangement with the dentist. Maximum savings are received when using a PPO Dentist.

PPO Dentist – Payment is based upon the PPO dentist's allowable fee, or the fee actually charged, whichever is less.

Premier Dentist – Payment is based upon the Premier Maximum Plan Allowance, or the fee actually charged, whichever is less.

Non-Participating Dentist – Payment is based upon the Premier Maximum Plan Allowance, or the fee actually charged, whichever is less.

Submission of Claims – Delta Dental PPO and Premier dentists will submit claims direct to Delta Dental

Delta Dental Provider Comparison
(Illustrative Purposes Only)

	DELTA DENTAL PPO DENTISTS IN-NETWORK	DELTA DENTAL PREMIER DENTISTS IN-NETWORK	NON-PARTICIPATING DENTISTS OUT-OF-NETWORK
Charged Fee (Filling)	$100.00	$100.00	$100.00
Maximum allowed*	$56.00	$80.00	$80.00
Benefit Percentage	80%	80%	80%
Benefit	$44.80	$64.00	$64.00
Member not Responsible	$44.00	$20.00	$0.00
Member Pays	**$11.20**	**$16.00**	**$36.00**

PPO Dentist – Payment is based upon the PPO dentist's allowable fee, or the fee actually charged, whichever is less.

Premier Dentist – Payment is based upon the Premier Maximum Plan Allowance, or the fee actually charged, whichever is less.

Non-Participating Dentist – Payment is based upon the Premier Maximum Plan Allowance, or the fee actually charged, whichever is less.

You will receive the highest level of coverage by choosing a PPO dentist.

* Allowable fee for a PPO dentist is the fee schedule which the dentist has agreed to charge. Allowable fee for a Premier dentist is the maximum amount per procedure that a Premier dentist can charge based on their contractual agreement with Delta Dental. Allowable fee for a non-participating dentist is equal to the Premier maximum allowable fee, however the dentist may charge the additional balance to the patient as they are not under contract with Delta Dental.

of Colorado and will only charge you the deductible and/or coinsurance you are responsible for (if any).

Non-participating dentists may require that you pay the full fee at time of service and submit your own claim. If your dentist will not submit the claim for you, you will need to complete a claim form and submit it to Delta Dental of Colorado. Claim forms are available at www.deltadentalco.com and www.hrs.colostate.edu/pdfs/delta-dental-claim-statement.pdf.

A separate claim form must be submitted for each member.

Dental Plan Appeals

Adverse Benefit Determination

An adverse Benefit Determination shall mean a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. An inquiry regarding eligibility or benefits without a Claim for benefits is not a Claim and therefore, cannot be appealed.

The Plan shall provide written or electronic notice of the determination on a Claim in a manner meant to be understood by the Claimant.

If the Claimant does not understand the reason for the Adverse Benefit Determination, the Claimant should contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

Appeal Process

A Covered Person has the right to appeal any adverse determination made on a claim, whether in whole or in part.

An appeal request may be submitted in writing within 180 days of the date of the original Explanation of Benefits to:

Delta Dental of Colorado
Appeals Analyst
PO BOX 172528
Denver, CO 80217-2528

A Covered Person may submit additional documentation in support of the appeal.

Second Level Appeal

If the Claimant does not agree with the Claims Administrator's determination from the first level review, the Claimant may submit a second level appeal in writing within 60 days of the Claimant's receipt of the Notice of Determination from the first level of review, along with any additional supporting information. Failure to appeal the determination from the first level of review within the 60 day period will render that determination final. The second level of review will be done by the Claims Administrator. The Claims Administrator will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination for the second level of review to the Claimant within 30 days of receipt of the appeal.

Third Level Appeal

These are conducted by an independent third party and are available only in those circumstances where benefits were denied and which have gone through the Level 2 Appeal process.

To request a Level 3 appeal, contact:

Benefits Appeal Committee
c/o Human Resources
Colorado State University
6004 Campus Delivery
Fort Collins, CO 80523-6004

The request for a Level 3 appeal must be made within 60 calendar days after the Level 2 denial.

EyeMed Vision Discount Plan

The EyeMed Discount Plan is available to all benefits eligible employees of Colorado State University and their benefit eligible dependents. The brochure and ID card for the plan can be downloaded from the Delta Dental website www.deltadentalco.com. On the left select "Subscriber", then under "Forms" on the right side choose "EyeMed Discount Plan" and view the benefits available to you.