



Delta Dental of New York

## THE NEW SCHOOL

*Combined Evidence of Coverage and Disclosure Form*



---

[deltadentalins.com](http://deltadentalins.com)

---

**Group No. 02019**

**Effective Date: 1/1/2014**

**Delta Dental**

Administrative Offices

One Delta Drive

Mechanicsburg, PA 17055-6999

(717) 766-8500 Toll free: (800) 932-0783

TTY/TDD: (888) 373-3582

[www.deltadentalins.com](http://www.deltadentalins.com)

**TABLE OF CONTENTS**

**INTRODUCTION..... 1**

    Using This Evidence of Coverage ..... 1

    Contact Us ..... 1

**SELECTING YOUR DENTIST ..... 1**

    Free Choice of Dentist ..... 1

    Referrals to Specialists ..... 2

    Locating a Delta Dental Participating Dentist ..... 2

**PLAN INFORMATION ..... 2**

    Benefit Summary Charts ..... 2

    Copayments ..... 5

    Deductible..... 5

    Maximum Benefit ..... 5

    Note on Additional Benefits During Pregnancy ..... 5

    Limitations and Exclusions..... 5

**HOW CLAIMS ARE PAID ..... 5**

    Payment for Services — Delta Dental PPO Dentist ..... 5

    Payment for Services — Delta Dental Premier Dentist..... 6

    Payment for Services — Non-participating Dentist..... 6

    Orthodontic Payments ..... 7

    How to Submit a Claim..... 7

    Payment Guidelines..... 7

    Optional Treatment and Non-Covered Services ..... 8

    Pre-Treatment Estimates ..... 8

    Other Health Insurance ..... 8

**ELIGIBILITY AND ENROLLMENT ..... 9**

    Eligibility Requirement ..... 9

    Changes in Eligibility Status..... 10

    Loss of Eligibility ..... 10

**COMPLAINTS, GRIEVANCES AND APPEALS..... 10**

    Appeals ..... 10

**GENERAL PROGRAM INFORMATION ..... 11**

    Proof of Claim..... 11

    Physical Access ..... 11

Access for the Hearing Impaired ..... 11

Privacy ..... 11

Web Site Security ..... 11

**ENROLLEE RIGHTS AND RESPONSIBILITIES ..... 11**

    The Right to Choose ..... 11

    The Right to Quality Assurance ..... 11

    The Right to Affordability ..... 12

    The Right to Full Disclosure ..... 12

    The Right to Fair Review and Appeal ..... 12

    The Responsibility to Protect These Rights ..... 12

**LIMITATIONS AND EXCLUSIONS ..... 12**

    Excluded Benefits..... 12

    Limitations..... 13

**DEFINITION OF TERMS..... 14**

**INTRODUCTION**

Delta Dental is pleased to welcome you to the group dental plan for The New School. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the dentist, but to see him/her on a regular basis.

**Using This Evidence of Coverage**

This Evidence of Coverage discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the plan works and how to obtain dental care. Please read this booklet completely and carefully. Keep in mind that YOU and YOUR mean the individuals who are covered. WE, US and OUR always refer to Delta Dental. In addition, please read the **Definition of Terms** section, which will explain any words that have special or technical meanings under the plan.

The benefit explanations contained in this booklet are subject to all provisions of the Group Dental Service Contract on file with your employer, trust fund, or other entity (“Plan Administrator”) and do not modify the terms and conditions of that contract in any way, nor shall you accrue any rights because of any statement in or omission from this booklet.

**Contact Us**

If you have any questions about your coverage that are not answered here, please visit our web site at [www.deltadentalins.com](http://www.deltadentalins.com) or call our Customer Service Center. A Customer Service Center representative can answer questions you may have about obtaining dental care, help you locate a participating dentist, explain benefits, check the status of a claim, and assist you in filing a claim.

Representatives are available by telephone Monday through Friday, 8:00 a.m. to 8:00 p.m. Eastern Time at (717) 766-8500 or toll-free at (800) 932-0783. If you are hearing impaired, you may call our toll-free TTY/TDD number at (888) 373-3582. You can also access Delta Dental’s automated information line at (800) 932-0783 to obtain information about enrollee eligibility and benefits, group benefits, or claim status.

If you prefer to write Delta Dental with your question(s), please mail your inquiry to the following address:

**Delta Dental  
One Delta Drive  
Mechanicsburg, PA 17055**

**SELECTING YOUR DENTIST**

**Free Choice of Dentist**

Delta Dental recognizes that many factors affect the choice of dentist and therefore supports your right to freedom of choice regarding your dentist. This assures that you have full access to the dental treatment you need from the dental office of your choice. You may see any licensed dentist for your covered treatment:

- Delta Dental PPO Participating Dentist (“PPO”)
- Delta Dental Premier Participating Dentist (“Premier”)
- Non-participating Dentist

In addition, you may choose your own specialist, and you and your family members can see different dentists.

**Remember, you enjoy the greatest savings when you choose a PPO dentist.** To take full advantage of your benefits, we highly recommend you verify a dentist’s participation status within a Delta Dental network with your dental office before each appointment. Review the section titled “How Claims Are Paid” for an explanation of Delta Dental payment procedures to understand the method of payments applicable to your dentist selection and how that may impact your out-of-pocket costs.

**Referrals to Specialists**

Your dentist may refer you to another dentist for a consultation or specialized treatment or you may elect to see a specialist on your own. If this is done, be sure that the dentist you are referred to is a participating dentist. You can do this by simply asking the specialist when you make your appointment. Visiting a dentist who has agreed to participate in the Delta Dental network can save you money, time, and the hassle of paperwork. Remember, if the dentist is not a participating dentist, you may be required to pay all of the treatment cost at the time of service and submit a claim to Delta Dental for reimbursement.

**Locating a Delta Dental Participating Dentist**

There are several ways in which you can locate a participating dentist near you:

- You may access information about the plan through our web site at [www.deltadentalins.com](http://www.deltadentalins.com). This web site includes a dentist search function allowing you to locate Delta Dental participating dentists by location, specialty and network type; or
- You may also call Delta Dental and one of our representatives will assist you. He/she can provide you with information regarding a dentist's membership status, specialty and office location.

**PLAN INFORMATION****Benefit Summary Charts**

The services provided through the plan include all the benefits described in the Benefit Summary Charts on the following pages, with the exception of those items presented in the **Limitations and Exclusions** section. The plan covers several categories of benefits when a licensed dentist provides the services and when they are within the standards of generally accepted dental practice. To help you understand the types of procedures that are included in each of the categories of services, examples and descriptions are provided in the charts. The enrollee's share may be higher than the percentages listed in the charts, depending on the applicability of deductibles, maximums, the difference between the Non-participating Dentist's fee and the Non-participating Dentist Maximum Plan Allowance or charges for non-covered services.

**The information in the following chart applies to services provided by Delta Dental PPO dentists only.**

**Benefit Summary Chart**

<b>Category of Service</b>	<b>Paid by Delta Dental</b>	<b>Paid By Enrollee</b>
<b>Diagnostic (deductible waived)</b> Periodic exams (twice per 12-month period) Bitewing x-rays (twice per 12-month period) Full-mouth x-ray (once per 3-year period) Palliative emergency treatment See note on additional benefits during pregnancy	100%*	0%
<b>Preventive (deductible waived)</b> Prophylaxis (cleaning) (twice per 12-month period) Fluoride treatments (twice per 12-month period to age 19) Sealants (to age 14) Space maintainers (to age 14) See note on additional benefits during pregnancy	100%*	0%
<b>Basic Restorative</b> Fillings (amalgam “silver” and composite “white” non-molar)	85%*	15%
<b>Major Restorative</b> Single crowns, inlays, onlays	50%*	50%
<b>Oral Surgery</b> Extraction and other oral surgery procedures, incl. pre- and post-operative care	85%*	15%
<b>Endodontics</b> Root canal, pulpal therapy	85%*	15%
<b>Surgical Periodontics</b> Surgical treatment of the gums and supporting structures of the teeth	85%*	15%
<b>Non-Surgical Periodontics</b> Non-surgical treatment of the gums and supporting structures of the teeth See note on additional benefits during pregnancy	85%*	15%
<b>Prosthodontics</b> Procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures	50%*	50%
<b>Orthodontics (deductible waived)</b> For eligible dependents to age 19	50%*	50%
<b>General Anesthesia</b> Covered when used in conjunction with covered oral surgical procedures	85%*	15%
<b>Temporomandibular Joint Dysfunction (TMJ)</b> Services relating to hinging joints of the jaw	0%*	100%
<b>Denture Repair &amp; Adjustments</b>	85%*	15%
<b>Occlusal Guards</b>	85%*	15%
	<b>Deductibles</b>	<b>Maximums</b>
Individual (Calendar year)	\$ 50.00	\$1,750.00
Family (Calendar year)	\$150.00	\$ n/a
Orthodontics (Lifetime)	\$ n/a	\$1,000.00

**\* For Delta Dental PPO dentists, percentages are based on the PPO Allowed Amount, which is the lesser of the dentist’s submitted fee or the PPO Maximum Plan Allowance.**

The information in the following chart applies to services provided by Delta Dental Premier dentists and Non-participating Dentists only.

**Benefit Summary Chart**

Category of Service	Paid by Delta Dental	Paid By Enrollee
<b>Diagnostic (deductible waived)</b> Periodic exams (twice per 12-month period) Bitewing x-rays (twice per 12-month period) Full-mouth x-ray (once per 3-year period) Palliative emergency treatment See note on additional benefits during pregnancy	100%*	0%
<b>Preventive (deductible waived)</b> Prophylaxis (cleaning) (twice per 12-month period) Fluoride treatments (twice per 12-month period to age 19) Sealants (to age 14) Space maintainers (to age 14) See note on additional benefits during pregnancy	100%*	0%
<b>Basic Restorative</b> Fillings (amalgam “silver” and composite “white” non-molar)	85%*	15%
<b>Major Restorative</b> Single crowns, inlays, onlays	50%*	50%
<b>Oral Surgery</b> Extraction and other oral surgery procedures, incl. pre- and post-operative care	85%*	15%
<b>Endodontics</b> Root canal, pulpal therapy	85%*	15%
<b>Surgical Periodontics</b> Surgical treatment of the gums and supporting structures of the teeth	85%*	15%
<b>Non-Surgical Periodontics</b> Non-surgical treatment of the gums and supporting structures of the teeth See note on additional benefits during pregnancy	85%*	15%
<b>Prosthodontics</b> Procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures	50%*	50%
<b>Orthodontics (deductible waived)</b> For eligible dependents to age 19	50%*	50%
<b>General Anesthesia</b> Covered when used in conjunction with covered oral surgical procedures	85%*	15%
<b>Temporomandibular Joint Dysfunction (TMJ)</b> Services relating to hinging joints of the jaw	0%*	100%
<b>Denture Repair &amp; Adjustments</b>	85%*	15%
<b>Occlusal Guards</b>	85%*	15%
	<b>Deductibles</b>	<b>Maximums</b>
Individual (Calendar year)	\$ 50.00	\$1,750.00
Family (Calendar year)	\$150.00	\$ n/a
Orthodontics (Lifetime)	\$ n/a	\$1,000.00

\* For Delta Dental Premier Dentists, percentages are based on the Premier Allowed Amount, which is the lesser of the dentist’s submitted fee or the Premier Maximum Plan Allowance. For Non-participating Dentists, percentages are based on the Non-participating Dentist Allowed Amount, which is the lesser of the dentist’s submitted fee or the Non-participating Dentist Maximum Plan Allowance.

**Copayments**

The plan will pay a percentage of the applicable allowed amount (PPO allowed amount for PPO dentists or Premier allowed amount for Premier and Non-participating Dentists) for each covered service, subject to certain limitations, and you are responsible for paying the balance. What you pay is called the copayment and is part of your out-of-pocket cost. You pay this even after a deductible has been met.

The amount of your copayment will depend on the type of service provided and the dentist providing the service (see section titled "Selecting Your Dentist"). Dentists are required to collect your copayment for covered services.

It is to your advantage to select PPO dentists because they have agreed to accept the PPO allowed amount as payment, which typically results in lower copayments charged to you. Please read the sections titled "Selecting Your Dentist" and "How Claims Are Paid" for more information.

**Deductible**

Most dental plans have a specific dollar deductible. The Benefit Summary Charts show the individual and family deductibles that apply, depending on the participation status of the dentist providing the services. Deductibles apply to all benefits unless otherwise noted. Each enrolled family member must pay the individual deductible amount each calendar year to satisfy the plan deductible. You pay this directly to your dentist for completed services. The total deductible amount paid will not exceed the family deductible for all family members.

**Maximum Benefit**

Most dental programs have a maximum benefit. This is the maximum dollar amount a dental plan will pay toward the cost of dental care. The enrollee is personally responsible for paying costs above the maximum benefit. The Benefit Summary Charts show the maximum benefit amount that applies, depending on the participation status of the dentist providing the services. This is the maximum benefit amount that Delta Dental will pay for covered services per enrollee in a calendar year.

**Note on Additional Benefits During Pregnancy**

When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services while the Enrollee is covered under the Contract include: one (1) additional oral exam and either one (1) additional routine cleaning or one (1) additional periodontal scaling and root planing per quadrant. Written confirmation of the pregnancy must be provided by the Enrollee or her dentist when the claim is submitted.

**Limitations and Exclusions**

Dental plans are designed to help with part of your dental expenses and may not always cover every dental need. The typical program includes limitations and exclusions, meaning the program does not cover every aspect of dental care. This can relate to the type of procedures or the number of visits. These limitations and exclusions are carefully detailed in this booklet and you should make yourself familiar with them. Please read the **Limitations and Exclusions** section to help you understand the limitations and exclusions of this dental plan.

**HOW CLAIMS ARE PAID**

Payment by Delta Dental for any single procedure that is a covered service will be made upon completion of the procedure. If an enrollee loses eligibility or the contract is terminated, Delta Dental will pay for any single procedure started while the contract was in effect or the enrollee was eligible. Payment for care is applied to the calendar year deductible and maximum benefit based on the date of service. After you have satisfied your deductible requirement, Delta Dental will provide payment for covered services at the percentage indicated in the Benefit Summary Chart, up to a maximum for each enrollee in a calendar year.

**Payment for Services — Delta Dental PPO Dentist**

Payment for covered services performed for you by a PPO dentist is calculated based on the PPO maximum plan allowance. PPO dentists have agreed to accept a PPO maximum plan allowance as the full charge for covered services.

Delta Dental calculates its share of the maximum plan allowance, or the dentist's submitted fee, whichever is less, ("Delta Dental Payment") using the applicable percentage from the Benefit Summary Chart and sends it directly to the PPO dentist who has submitted the claim. Delta Dental advises you of any charges not payable by Delta Dental for which you are responsible ("Patient Payment"). These charges are generally your share of the maximum plan allowance or submitted fee (copayment), the deductible, charges where the maximum benefit has been exceeded, and/or charges for non-covered services.

Example (assuming this is a procedure that is covered at a 50%/50% copayment level, the maximum benefit has not been exceeded and the deductible has been met):

Submitted Amount (Dentist Fee)	= \$100
PPO Maximum Plan Allowance	= \$70
PPO Allowed Amount	= \$70
Co-payment (50% of PPO Allowed Amount)	= \$35
Delta Dental Payment	= \$35
Enrollee Payment	= \$35

### **Payment for Services — Delta Dental Premier Dentist**

A Delta Dental Premier dentist is a participating dentist, but is not a Delta Dental PPO dentist. Premier dentists have not agreed to accept a PPO maximum plan allowance as full payment for services, but instead have agreed to accept a Premier maximum plan allowance. Payment for covered services performed for you by a Premier dentist is calculated based on the Premier allowed amount, which is the lesser of the dentist's submitted fee or the Premier maximum plan allowance.

The portion of the Premier allowed amount payable by Delta Dental ("Delta Dental's Payment") is limited to the applicable percentage shown in the Benefit Summary Chart. Delta Dental's Payment is sent directly to the Premier dentist who submitted the claim. Delta Dental advises you of any charges not payable by Delta Dental for which you are responsible ("Enrollee's Payment"). These charges are generally your share of the Premier allowed amount, as well as any deductibles, charges where the maximum benefit has been exceeded, and/or charges for non-covered services.

Example (assuming this is a procedure that is covered at a 50%/50% copayment level, the maximum benefit has not been exceeded and the deductible has been met):

Submitted Amount (Dentist Fee)	= \$100
Premier Maximum Plan Allowance	= \$80
Premier Allowed Amount	= \$80
Co-payment (50% of Premier Allowed Amount)	= \$40
Delta Dental Payment	= \$40
Enrollee Payment	= \$40

### **Payment for Services — Non-participating Dentist**

Payment for services performed for you by a Non-participating Dentist is also calculated by Delta Dental based on the Non-participating Dentist Allowed Amount, which is the lesser of the dentist's submitted fee or the Non-participating Dentist Maximum Plan Allowance. The portion of the Non-participating Dentist Allowed Amount payable by Delta Dental ("Delta Dental's Payment") is limited to the applicable percentage shown in the Benefit Summary Chart.

However, when dental services are received from a Non-participating Dentist, Delta Dental's Payment is sent directly to the primary enrollee. You are responsible for payment of the Non-participating Dentist's total fee. Non-participating Dentists will bill you for their normal charges, which may be higher than the Non-participating Dentist Allowed Amount for the service. You may be required to pay the dentist yourself and then submit a claim to Delta Dental for reimbursement. Since the Delta Dental Payment for services you receive may be less than the Non-participating Dentist's actual charges, your out-of-pocket cost may be significantly higher.

Example (assuming this is a procedure that is covered at a 50%/50% copayment level, the maximum benefit has not been exceeded and the deductible has been met):

Submitted Amount (Dentist Fee)	= \$100
Non-participating Dentist Maximum Plan Allowance	= \$80
Non-participating Dentist Allowed Amount	= \$80
Co-payment (50% of Non-participating Dentist Allowed Amount)	= \$40
Delta Dental Payment	= \$40
Enrollee Payment	= \$60

**Note:** The enrollee balance of \$60 is the sum of the enrollee copayment (50% of the Non-participating Dentist Maximum Plan Allowance of \$80, which is \$40) and the difference between the Non-participating Dentist Allowed Amount and the Submitted Amount, which is \$20.

### **Orthodontic Payments**

Unless otherwise specified in the contract, Delta Dental will pay half of its orthodontic payment up front, at the time of banding. (Delta Dental's orthodontic payment is calculated in the same manner as the "Delta Dental Payment" in the above examples.) The remaining half will be paid one year later. If the treatment time is 12 months or less, Delta Dental's orthodontic payment will be paid as a lump sum at the beginning of the orthodontic treatment. If treatment began prior to the enrollee becoming eligible with Delta Dental, any payments made by a previous dental carrier will be applied to the enrollee's lifetime orthodontic maximum.

### **How to Submit a Claim**

Delta Dental does not require any special claim forms. Most dental offices have standard claim forms available. Participating dentists will fill out and submit your claims paperwork for you. Some Non-participating Dentists may also provide this service upon your request. If you receive services from a Non-participating Dentist who does not provide this service, you can submit your own claim directly to Delta Dental. For your convenience, you can print a claim form from our web site: [www.deltadentalins.com](http://www.deltadentalins.com). Delta Dental shall not be obligated to pay claims submitted more than twelve (12) months after the date of the Service, unless it can be shown not to have been reasonably possible to submit the claim and the claim was submitted as soon as reasonably possible.

Your dental office should be able to assist you in filling out the claim form. Fill out the claim form completely and mail it to:

**Delta Dental**  
**P.O. Box 2105**  
**Mechanicsburg, PA 17055-6999**

### **Payment Guidelines**

Delta Dental does not pay participating dentists any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If you or your dentist files a claim for services more than twelve (12) months after the date you received the services, payment may be denied. If the services were received from a Non-participating Dentist, you are still responsible for the full cost. If the payment is denied because your participating dentist failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your participating dentist that you were an enrollee of the plan at the time you received the service, you may be responsible for the cost of that service.

We explain to all participating dentists how we determine or deny payment for services. We describe in detail the dental procedures covered as benefits, the conditions under which coverage is provided and the program's limitations and exclusions. If any claims are not covered, or if limitations or exclusions apply to services you have received, you may be responsible for the full payment.

If you have any questions about any dental charges, processing policies and/or how your claim is paid, contact Delta Dental.

**Optional Treatment and Non-Covered Services**

You must pay for any non-covered or optional dental benefits that you choose to have done. Refer to the **Limitations and Exclusions** section for information about excluded services and limitations.

Often there are several approaches or different methods that a dentist may use to treat dental needs. This program is designed to cover dental treatment using standards of care consistent with the delivery of quality, affordable dental treatment to the enrollee. If you request a treatment that is more costly than standard practice, you must pay for the charges in excess of the covered dental benefit.

**Example:** If a metal filling would fix the tooth and you choose to have the tooth crowned, you are responsible for paying the difference between the cost of the crown and the cost of the filling. You must pay this money directly to your dentist.

**Pre-Treatment Estimates**

If you and your dentist are unsure of your benefits for a specific course of treatment, or if treatment costs are expected to exceed \$300, Delta Dental recommends that you ask for a pre-treatment estimate. You should ask your dentist to submit the claim form in advance of performing the proposed services. Pre-treatment estimate requests are not required but may be submitted for more complicated and expensive procedures such as crowns, wisdom tooth extractions, bridges, dentures, or periodontal surgery. You'll receive an estimate of your share of the cost and how much Delta Dental will pay before treatment begins. Delta Dental will act promptly in returning a pre-treatment estimate to you and the attending dentist with non-binding verification of your current availability of benefits and applicable maximums. The pre-treatment estimate is non-binding as the availability of benefits may change subsequent to the date of the estimate due to a change in eligibility status, exhaustion of applicable maximum benefit or application of frequency of procedure limitations.

**Other Health Insurance**

Be sure to advise your dentist of all programs under which you have dental coverage and have him or her complete the dual coverage portion of the claim form, so that you will receive all benefits to which you are entitled. When you have coverage under more than one benefit program, the primary and secondary carriers coordinate the two programs, so that the primary carrier pays its portion first and then the secondary carrier pays its portion, not to exceed the dentist's fees for the covered services.

The following rules will be followed to establish the order of determining the liability of this or any other programs:

1. The program covering the enrollee as an employee will determine its benefits before the program covering the enrollee as a dependent.
2. The program covering the enrollee as a dependent of an employee whose birthday falls earlier in the calendar year will determine its benefits before the program covering the enrollee as a dependent of an employee whose birthday falls later in the calendar year. If both employees have the same birthday, the program covering the employee for the longest period will be primary over the program covering the employee for the shorter period. If the other program does not have the rule described in this paragraph, but instead has a rule based on gender of the employee, the rule of the other plan will determine the order of benefits.
3. The program covering the enrollee having custody of the dependent will determine its benefits first; then the program of the spouse of the parent with custody of the dependent; and finally, the program of the parent not having custody of the dependent. However, if the specific terms of a court order state that one of the parents is responsible for the health care expenses of the dependent, the benefits of that program are considered first. The prior sentence will not apply with respect to any period during which any benefits are actually paid or provided before a program has actual knowledge of the court order.
4. The program covering the enrollee as an employee or as a dependent of an employee will determine its benefits before one that covers the enrollee as a laid-off or retired employee or as the dependent of such person. If the other plan does not have a rule concerning laid-off or retired employees, and as a result each plan determines its benefits after the other, then this paragraph will not apply.

5. If the other program does not have a rule establishing the same order of determining liability for benefits or is one which is “excess” or always “secondary,” Delta Dental will determine its benefits first. If such determination indicates that Delta Dental should not have been the first program to determine its benefits, Delta Dental will be considered as not the first to determine its benefits.
6. In situations not described in items 1 through 5, the program under which the enrollee has been enrolled for the longest period of time will determine its benefits first.

When Delta Dental is the first to determine its benefits, benefits will be paid without regard to coverage under any other program. When Delta Dental is not the first to determine its benefits, and there are remaining expenses of the type allowable under this program, Delta Dental will pay only the amount by which its benefits under this plan exceed the amount of benefits payable under the other program or the amount of such remaining expenses, whichever is less.

## **ELIGIBILITY AND ENROLLMENT**

### **Eligibility Requirement**

You will become eligible to receive benefits on the date stated in the contract after completing any eligibility periods required by the group. Under this dental plan, the eligibility requirement for new hires is the first of the month following 30 days of employment. You may enroll for individual and family coverage.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents. Dependents are your:

- Spouse.
- Married or unmarried children and/or dependent grandchildren until the end of the Calendar-Year of their 26th birthday. Such children include: (a) your biological child, (b) your legally adopted child (including a child living with the adopting parents and/or grandparents during the period of probation), (c) a child for whom you have legal guardianship or temporary guardianship of more than 12 months duration and for a shorter period if the guardianship is of a dependent minor and granted by testamentary, (d) a stepchild. Documentation of the above must be furnished upon request by Delta Dental.
- Married or unmarried children and/or dependent grandchildren of any age who are incapable of self-support by reason of mental or physical incapacity that occurred before the age of 26 (end of the Calendar-Year) and were covered prior to age 26 (end of the Calendar-Year). The dependent child must also be chiefly dependent on you for support and maintenance, but is not required to reside with a parent or legal guardian who is a primary enrollee. Eligibility of these dependent children and/or grandchildren will not be terminated while the contract remains in force and the dependent child and/or grandchild remains in such condition. Proof of physical or mental disability must be furnished as required by Delta Dental.
- Newborn children and/or dependent grandchildren of any primary enrollee for 31 days from: (a) the moment of birth, (b) the date of placement for adoption or upon placement in the foster home, or (c) the date of appointment for a minor for whom guardianship has been granted by court or testamentary appointment. Proof of birth or adoption or foster home placement must be furnished upon request by Delta Dental. In order for the coverage to continue beyond the 31-day period, you must notify the Plan administrator of the birth, adoption, placement in the foster home, or appointment of guardianship.
- A domestic partner.
- Married or unmarried children of a domestic partner.

**Changes in Eligibility Status**

Changes in eligibility status (i.e. marriage, divorce, birth, etc.) must be reported to the Plan Administrator within 31 days following the event causing the change. If you do not change coverage when first eligible, you may change later during a subsequent open enrollment period. Changes received from the 1<sup>st</sup> of the month through the 15<sup>th</sup> of the month become effective on the 1<sup>st</sup> of the month in which the notice is received. Changes received from the 15<sup>th</sup> of the month through the last day of the month become effective on the 1<sup>st</sup> of the following month.

**Loss of Eligibility**

Your coverage ends on the last day of the month in which termination of employment occurs or immediately when this program ends. Coverage for all dependents also ceases at that time, or when dependent status is lost. Your dependent children and/or grandchildren will be disqualified for benefits when they reach the disqualifying age.

**COMPLAINTS, GRIEVANCES AND APPEALS**

Our commitment to you is to ensure quality throughout the entire treatment process: from the courtesy extended to you by our customer service representatives to the dental services provided by our participating dentists. If you have questions about any services received, we recommend that you first discuss the matter with your dentist. However, if you continue to have concerns, please call Delta Dental’s Customer Service Center.

Delta Dental attempts to process all claims within 30 days. If a claim will be delayed more than 30 days, Delta Dental will notify the enrollee in writing within 30 days stating the reason for delay.

Questions or complaints regarding eligibility, the denial of dental services or claims, the policies, procedures, or operations of Delta Dental, or the quality of dental services performed by the dentist may be directed in writing to Delta Dental or by calling Delta Dental at (717) 766-8500 or toll-free at (800) 932-0783. You can also e-mail questions by accessing the “Contact Us” section of Delta Dental’s web site at [www.deltadentalins.com](http://www.deltadentalins.com).

A grievance is a written expression of dissatisfaction with the provision of services or claims practices of Delta Dental. When you write, please include the name of the enrollee, the primary enrollee’s name and enrollee ID, and your telephone number on all correspondence. You should also include a copy of the claim form, Benefits Statement, Invoice or other relevant information.

**Appeals**

Any dissatisfaction with adjustments made or denials of payment should be brought to Delta Dental’s attention, and if unresolved to your satisfaction, to the Plan Administrator. The Plan Administrator will advise you of your rights of appeal or other recourse.

Appeals on claims denied must be submitted in writing. For an explanation as to your rights of appeal, please refer to the Claims Denial Review Procedure that is furnished automatically without charge as a separate document that accompanies this booklet.

**Send your grievance, appeal, or claims review request to Delta Dental at the address shown below:**

**Delta Dental  
One Delta Drive  
Mechanicsburg, PA 17055**

**GENERAL PROGRAM INFORMATION****Proof of Claim**

Before approving a claim, Delta Dental will be entitled to receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which a dentist's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, an enrollee as may be required to administer the claim, or that an enrollee be examined by a dental consultant retained by Delta Dental, in or near the community or residence. Delta Dental will in every case hold such information and records confidential.

**Physical Access**

Delta Dental has made efforts to ensure that our offices and the offices and facilities of participating dentists are accessible to the disabled. If you are not able to locate an accessible dentist, please call our Customer Service Center and a representative will help you find an alternate dentist.

**Access for the Hearing Impaired**

The hearing impaired may contact the Customer Service Center through our toll-free TTY/TDD number at (888) 373-3582.

**Privacy**

Delta Dental values its relationship with you. Protecting your personal information is of great importance to us. Delta Dental will obtain from the enrollee only nonpublic information that relates to Delta Dental's administration of the dental benefits we provide. Information may include, but not be limited to name, address, social security number, enrollee ID, and date of birth. We do not disclose any nonpublic personal information about you to any affiliated or nonaffiliated third parties except as is necessary in order to provide our service to you or as we are required or permitted by law. Delta Dental maintains physical, electronic, and procedural security measures to safeguard your nonpublic personal information in our possession.

**Web Site Security**

Delta Dental employs security measures to control access to the eligibility and dental benefit information under our control. Delta Dental uses industry standards, such as firewalls and Secure Socket Layers, to safeguard the confidentiality of personal enrollee information.

There are areas of our web site that require a specific user ID and password for web site access. In order to receive a user ID and password, Delta Dental requires enrollees to contractually agree to not provide information they may access to other individuals. The user identification and password required for site access is internally validated to ensure this information cannot be viewed without proper authority and security authentication.

**ENROLLEE RIGHTS AND RESPONSIBILITIES**

We believe that you, as a Delta Dental enrollee, have the right to expect quality, affordable care that protects not only your dental health, but also your privacy and ability to make informed choices. We also believe that you have certain responsibilities to help protect these rights.

**The Right to Choose**

The Delta Dental system maintains some of the largest dentist networks in the industry — each with a full range of specialists — to give you the widest possible choice of dentists. Dentists are never penalized for referring you to a specialist. You can visit any dentist at any time, without prior notification or authorization from Delta Dental.

**The Right to Quality Assurance**

While we support the right of enrollees to choose their dentist, we recognize our responsibility to provide some assurances of quality care.

Therefore, each dentist who has contracted with Delta Dental agrees to provide care that meets the standards of the dental profession. Dentist contracts allow Delta Dental to audit dental offices in person — at random and for cause — to help ensure that these standards are met. If you should ever receive substandard care from a Delta Dental dentist, Delta Dental will fully investigate the matter and can arrange for you to be reimbursed and/or retreated as needed.

### **The Right to Affordability**

Delta Dental contracts with dentists to provide fair and reasonable compensation. Those contracts also prohibit dentists from billing you for excess charges, “add-on” procedures that should already be included, or for any amount that is Delta Dental’s responsibility.

Delta Dental benefit plans are designed to promote preventive care, avoiding dental disease before more costly treatment becomes necessary.

### **The Right to Full Disclosure**

You have the right to clear and complete information about your dental benefits, including treatment that is subject to limitations or not covered. You are entitled to know what your share of costs will be before you receive treatment (“pre-treatment estimate”), and how your dentist is compensated by Delta Dental. Delta Dental provides materials to explain these features to you.

Delta Dental dentists are not subject to policies sometimes called “gag clauses.” You are entitled to hear about all treatment options your dentist may recommend, whether covered or not, and to obtain a second opinion if you choose.

### **The Right to Fair Review and Appeal**

Delta Dental supports your right, as well as your dentist’s, to a fair and prompt review of any of Delta Dental’s coverage decisions. We maintain effective complaint resolution systems in the event of disagreement over coverage or concern about the quality of care.

### **The Responsibility to Protect These Rights**

Protection of the rights described above is possible only with your cooperation. In order to ensure the continued enjoyment of these rights, you share:

- The responsibility to participate in your own dental health — practicing personal dental hygiene and receiving regular professional care. You should avoid substances and behaviors that could jeopardize your oral health, and should cooperate with your dentist on his or her recommended treatment plans.
- The responsibility to become familiar with your coverage. This includes meeting any financial obligation incurred as a result of treatment (including the appropriate copayments or deductibles required by the program). It means cooperation with Delta Dental policies designed to protect against health care fraud schemes by fellow enrollees or dentists. It also means taking advantage of the information available on dental health and your dental program so that you can become a more informed consumer.

## **LIMITATIONS AND EXCLUSIONS**

### **Excluded Benefits**

The plan covers a wide variety of dental care expenses, but there are some services for which we do not provide benefits. It is important for you to know what these services are before you visit your dentist.

The plan does not provide benefits for:

1. Surgical procedures including but not limited to reduction of fractures, removal of tumors and removal of impacted teeth are subject to the provisions described in the **Other Health Insurance** section of this booklet.
2. Treatment or materials with respect to skeletal malformation, except for treatment due to accidental injury to sound natural teeth within 12 months of the accident or treatment necessary due to congenital disease or anomaly, or treatment of enamel hypoplasia (lack of

development), except that this exclusion shall not apply to covered dependent children or eligible newborn children so long as such dependent children continue to be eligible. When services are not excluded under this provision as to these dependent children who continue to be eligible, other limitations and exclusions of this section shall specifically apply.

3. Treatment that increases the vertical dimension of an occlusion, replaces tooth structure lost by attrition or erosion, or otherwise unless it is part of a treatment dentally necessary due to accident or injury.
4. Treatment or materials primarily for cosmetic purposes including but not limited to treatment of fluorosis (a type of discoloration of the teeth) and porcelain or other veneers not for restorative purposes, except as part of a treatment dentally necessary due to accident or injury and except for reconstructive surgery necessary because of a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. If services are not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent or near the affected teeth are excluded.
5. Treatment or materials for which the enrollee would have no legal obligation to pay.
6. Services provided or materials furnished prior to the effective eligibility date of an enrollee under this plan, unless the treatment was a year in duration and completed after the enrollee became eligible if no other limitations shall apply.
7. Periodontal splinting, equilibration, gnathological recordings and associated treatment and extra-oral grafts.
8. Preventive plaque control programs, including oral hygiene instruction programs.
9. Myofunctional therapy, unless covered by the exception in Item 2, above.
10. Temporomandibular joint dysfunction treatment that is medical in nature.
11. Prescription drugs including topically applied medication for treatment of periodontal disease, pre-medication, analgesias, separate charges for local anesthetics, general anesthesia except as a covered benefit in conjunction with a covered oral surgery procedure.
12. Implants and related services, unless covered by the exception Item 2, above.
13. Experimental procedures that have not been accepted by the American Dental Association.
14. Services provided or material furnished after the termination date of coverage for which premium has been paid, as applicable to individual enrollees, except this shall not apply to services commenced while the plan was in effect or the enrollee was eligible.
15. Charges for hospitalization or any other surgical treatment facility, including hospital visits.
16. Dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks, or relaxation techniques such as music.
17. Replacement of existing restorations for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.
18. Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered benefit.

**Limitations**

Benefits to enrollees are limited as follows:

**Limitation on Optional Treatment Plan.** In all cases in which there are optional plans of treatment carrying different treatment costs, payment will be made only for the applicable percentage of the least costly course of treatment, so long as such treatment will restore the oral condition in a professionally

accepted manner, with the balance of the treatment cost remaining the responsibility of the enrollee. Such optional treatment includes, but is not limited to, specialized techniques involving gold, precision partial attachments, overlays, implants, bridge attachments, precision dentures, personalization or characterization such as jewels or lettering, shoulders on crowns or other means of unbundling procedures into individual components not customarily performed alone in generally accepted dental practice.

**Limitation on Major Restorative Benefits.** If a tooth can be restored with amalgam, synthetic porcelain or plastic, but the enrollee and the dentist select another type of restoration, the obligation of Delta Dental shall be only to pay the applicable percentage of the fee appropriate to the least costly restorative procedure. The balance of the treatment shall be considered a dental treatment excluded from coverage under this plan.

- Replacement of crowns, jackets, inlays and onlays shall be provided no more often than once in any five-year period and then only in the event that the existing crown, jacket, inlay or onlay is not satisfactory and cannot be made satisfactory. The five-year period shall be measured from the date on which the restoration was last supplied, whether paid for under the provisions of this plan, under any prior dental care contract, or by the enrollee.

**Limitation on Prosthodontic Benefits.** Replacement of an existing denture will be made only if it is unsatisfactory and cannot be made satisfactory. Services, including denture repair and relining, which are necessary to make such appliances fit will be provided as outlined in the section "Covered Benefits." Prosthodontic appliances and abutment crowns will be replaced only after five years has elapsed following any prior provision of such appliances and abutment crowns under any plan procedure.

**Limitation on Orthodontic Benefits.** Orthodontic benefits are limited to devices and procedures for the correction of malposed teeth of dependents up to age 19, through the completion of the procedures; or to the date coverage terminates, which ever occurs first. The obligation of Delta Dental to make monthly or other periodic payments for orthodontic treatment will cease upon termination of treatment for any reason, prior to completion of the procedure. Delta Dental will not make any payment for repair or replacement of orthodontic appliances.

**Limitation on Periodontal Surgery.** Benefits for periodontal surgery in the same quadrant are limited to once in any five-year period. The five-year period shall be measured from the date on which the last periodontal surgery was performed in that quadrant, whether paid for under the provisions of this plan, under any prior dental contract, or by the enrollee.

**Limitation on Sealants.** Treatment with sealants as a covered Service is limited to applications to eight posterior teeth. Applications to deciduous teeth or teeth with caries are not covered Services. Sealants will be replaced only after three (3) years have elapsed following any prior provision of such materials.

**Limitation on Occlusal Restorations.** Single-surface occlusal restorations of a tooth to which a sealant has been applied within twelve months, and two or three surface restorations within six months, which include occlusal surfaces on which sealants have been placed are not covered Services. If a single-surface occlusal restoration is performed on a tooth from twelve to thirty-six months after a sealant has been applied to that tooth, the obligation of Delta Dental shall be only to pay the fee appropriate to the restoration in excess of the fee paid for the application of the sealant.

## **DEFINITION OF TERMS**

The following are definitions of words that have special or technical meanings under the plan.

**Attending Dentist Statement:** The written report of a series of procedures recommended for the treatment of a specific dental disease, defect or injury, prepared for an enrollee by a dentist as a result of an examination made by such dentist.

**Benefits Statement:** The statement you receive after a claim is processed, detailing how your claim payment was calculated including the procedures and fees submitted and the amount for which you are responsible.

**Calendar Year:** The time period beginning on January 1<sup>st</sup> and ending on December 31<sup>st</sup>.

**Claim Form:** A written or electronically submitted document to request payment for completed dental treatment or to request a pre-treatment estimate for proposed dental treatment. The claim form is also sometimes called an Attending Dentist's Statement.

**Company:** The employer, union or other organization or group contracting to obtain benefits.

**Contract:** The written agreement between Delta Dental and The New School to provide dental benefits. The contract, together with this Evidence of Coverage, forms the terms and conditions of benefits available to you under the dental plan.

**Contract Year:** The 12-month period beginning on the effective date and each yearly period thereafter.

**Copayment:** Your share of the cost of a covered service, usually expressed as a percentage of the applicable allowed amount.

**Deductible:** The dollar amount enrollees must pay toward completed treatment before Delta Dental's payment is applied to those services in a given period.

**Delta Dental Payment:** The portion of the PPO Allowed Amount, the Premier Allowed Amount or the Non-participating Dentist Allowed Amount payable by Delta Dental.

**Delta Dental PPO with Point of Service (POS) Option:** A dental care program under which all fees paid by Delta Dental for covered services provided by a PPO dentist shall be based on the PPO allowed amount, subject to any applicable copayments, deductibles and maximums. All fees paid by Delta Dental for services provided by a Premier dentist who is not a PPO dentist or by a Non-participating Dentist shall be based on the Premier allowed amount.

**Delta Dental PPO ("PPO") Dentist:** A participating dentist who is a member of the Delta Dental PPO dentist network.

**Delta Dental Premier ("Premier") Dentist:** A participating dentist who is a member of the Delta Dental Premier dentist network.

**Delta Dental PPO ("PPO") Maximum Plan Allowance:** The maximum amount payable by Delta Dental for a covered dental service if the subscriber is enrolled in a PPO program. Delta Dental establishes the maximum plan allowance for each procedure through a review of proprietary filed fee data and actual submitted claims. Maximum plan allowances are typically set annually to reflect charges based on actual submitted claims from dentists in the same geographical area with similar professional standing. The subscriber's financial obligation beyond the maximum plan allowance is determined by any maximums, deductible and co-payment amounts.

**Delta Dental Premier ("Premier") Maximum Plan Allowance:** The maximum amount payable by Delta Dental for a covered dental service if the subscriber is enrolled in a Premier program. Delta Dental establishes the maximum plan allowance for each procedure through a review of proprietary filed fee data and actual submitted claims. Maximum plan allowances are typically set annually to reflect charges based on actual submitted claims from dentists in the same geographical area with similar professional standing. The enrollee's financial obligation beyond the maximum plan allowance is determined by any maximums, deductible and copayment amounts.

**Dependent:** Eligible family members as defined in the **Eligibility and Enrollment** section of this Evidence of Coverage.

**Effective Date:** The date the dental program begins. This date is given on the front cover of this Evidence of Coverage.

**Employee:** An employee of the company who meets the eligibility requirements, accepted by Delta Dental, for enrollment under the contract, and who is so specified for enrollment.

**Enrollee:** Collectively, the primary enrollee and all enrolled dependents.

**Exclusions:** Services that are not covered under this dental plan.

**Family:** The primary enrollee and all enrolled dependents of the primary enrollee.

**Limitations:** The number of services allowed, frequency of services allowed, and the most affordable dentally appropriate service.

**Maximum Benefit:** The total maximum dollar amount Delta Dental will pay toward the cost of covered dental care incurred by an individual enrollee in a given period.

**Network:** A collective expression for all participating dentists who have contracted with Delta Dental to offer services to enrollees and who have agreed to abide by certain administrative guidelines.

**Non-participating Dentist:** A dentist who has not contracted with Delta Dental and who is not contractually bound to abide by Delta Dental's administrative guidelines.

**Non-participating Dentist Allowed Amount:** For covered services, the Non-participating Dentist Allowed Amount under this plan is the lesser of the dentist's submitted fee or the Non-participating Dentist Maximum Plan Allowance. For non-covered services, the Non-participating Dentist Allowed Amount is zero.

**Non-participating Dentist Maximum Plan Allowance:** The maximum amount payable by Delta Dental for a covered dental service if the enrollee is enrolled in a Delta Dental PPO program. Delta Dental defines the Non-participating Dentist Maximum Plan Allowance for each procedure up to the 90th percentile of FairHealth as published in the FH™ Benchmarks. The enrollee's financial obligation beyond the Non-participating Dentist Maximum Plan Allowance is determined by any maximums, deductible and co-payment amounts.

**Out-of-Pocket Costs:** The portion of dental fees that you pay. Out-of-pocket costs include your deductible, copayment, any amount exceeding the maximum benefit amount, and services not covered by the dental plan.

**Participating Dentist:** A dentist who contracts with Delta Dental and agrees to abide by certain administrative guidelines.

**PPO Allowed Amount:** For covered services, the PPO allowed amount under this plan is the lesser of the dentist's submitted fee or the PPO maximum plan allowance. For non-covered services, the PPO allowed amount is zero.

**Premier Allowed Amount:** For covered services, the Premier allowed amount under this plan is the lesser of the dentist's submitted fee or the Premier maximum plan allowance. For non-covered services, the Premier allowed amount is zero.

**Pre-Treatment Estimate:** A pre-treatment estimate gives a non-binding estimate of how much of a proposed treatment plan will be covered under an enrollee's dental program and what the enrollee's out-of-pocket cost will be.

**Primary Enrollee:** An employee who is enrolled in this dental plan.

**Services:** Treatment performed by a dentist or under his/her supervision and direction and when necessary, customary and reasonable, as determined by Delta Dental, using standards of generally accepted dental practice.

**Single Procedure:** A dental procedure to which a separate procedure number is assigned by Delta Dental.

**Submitted Amount:** The amount the dental office actually submits on the claim form. This is the fee normally charged by the dentist for services provided to all enrollees, regardless of insurance coverage.

**Treatment:** A caring for or dealing with an oral condition.

**APPENDIX A**

(1) *Denial of payment based upon lack of coverage of benefit under the Contract or Enrollee's eligibility status i.e., claim benefit determinations that are **not** considered Utilization Review under Article 49 of the New York Insurance Law.*

If a post-service claim<sup>1</sup> is denied in whole or in part, Delta Dental shall notify the Enrollee and the attending dentist of the denial in writing within thirty (30) days after the claim is filed, unless special circumstances require an extension of time, not exceeding fifteen (15) days, for processing. If there is an extension, the Enrollee and the attending dentist shall be notified of the extension and the reason for the extension within the original thirty (30) day period. If an extension is necessary because either the Enrollee or the attending dentist did not submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information. The Enrollee or the attending dentist shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specific information. The extension period (15 days) – within which a decision must be made by Delta Dental – will begin to run from the date on which the Enrollee's response is received by the plan (without regard to whether all of the requested information is provided) or, if earlier, the due date established by the plan for furnishing the requested information (at least 45 days).

The notice of denial shall explain the specific reason or reasons why the claim was denied in whole or in part, including a specific reference to the pertinent Contract provisions on which the denial is based, a description of any additional material or information necessary for the Enrollee to perfect the claim and an explanation as to why such information is necessary. The notice of denial shall also contain an explanation of Delta Dental's claim review and appeal process and the time limits applicable to such process, including a statement of the Enrollee's right to bring a civil action under ERISA upon completion of Delta Dental's second level of review. The notice shall refer to any internal rule, guideline, and protocol that was relied upon (and that a copy will be provided free of charge upon request).-

If the Enrollee or the attending dentist wants the denial of benefits reviewed, the Enrollee or the attending dentist must write to Delta Dental within one hundred eighty (180) days of the date on the denial letter. In the letter, the Enrollee or attending dentist should state why the claim should not have been denied. Also any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. The Enrollee or the attending dentist is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review

---

<sup>1</sup> Delta Dental does not condition receipt of a benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care. Additionally, Delta Dental does not conduct concurrent review relating to continued or extended health care services, or additional services for an insured undergoing a course of continued treatment.

## DELTA DENTAL OF NEW YORK, INC.

will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination. The review shall be conducted on behalf of Delta Dental by a person who is neither the individual who made the claim denial that is the subject of the review, nor the subordinate of such individual. If the review is of a claim denial based in whole or in part on a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta Dental dental consultant whose advice was obtained in connection with the denial of the claim whether or not the advice was relied upon in making the benefit determination is also available to the Enrollee or the attending dentist upon request. In making the review, Delta Dental will not afford deference to the initial adverse benefit determination.

If after review, Delta Dental continues to deny the claim, Delta Dental shall notify the Enrollee and the attending dentist in writing of the decision on the request for review within thirty (30) days of the date the request is received. Delta Dental shall send to the Enrollee or attending dentist a notice, which contains the specific reason or reasons for the adverse determination and reference to the specific Contract provisions on which the benefit determination is based. The notice shall state that the Enrollee is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the Enrollee's claim for benefits. The notice shall refer to any internal rule, guideline, and protocol that was relied upon (and that a copy will be provided free of charge upon request). The notice shall state that if the claim denial is based on lack of dental necessity, experimental treatment or a clinical judgment in applying the terms of the Contract, an explanation is available free of charge upon request by either the Enrollee or the attending dentist. The notice shall also state that the Enrollee has a right to bring an action under ERISA upon completion of Delta Dental's second level of review, and shall state: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If in the opinion of the Enrollee or attending dentist, the matter warrants further consideration, the Enrollee or the attending dentist should advise Delta Dental in writing as soon as possible. The matter shall then be immediately referred to Delta Dental's Dental Affairs Committee. This stage can include a clinical examination, if not done previously, and a hearing before Delta Dental's Dental Affairs Committee if requested by the Enrollee or the attending dentist. The Dental Affairs Committee will render a decision within thirty (30) days of the request for further consideration. The decision of the Dental Affairs Committee shall be final insofar as Delta Dental is concerned. Recourse thereafter would be to the state regulatory agency, a designated state administrative review board, or to the courts with an ERISA or other civil action.

(2) Denial of a covered benefit where the service is not dentally necessary, appropriate or efficient, i.e., claim benefit determinations that are considered Utilization Review under Article 49 of the New York Insurance Law.

See Attachment One.

**ATTACHMENT ONE**

**DELTA DENTAL OF NEW YORK'S UTILIZATION REVIEW AND  
INTERNAL APPEALS PROCEDURES**

I. Definitions

- A. Adverse Determination shall mean a determination by a Utilization Review Agent that an admission, extension of stay, or other health care service, upon review based on the information provided, is not medically necessary.
- B. Appeal Determination shall mean a determination by Delta Dental of New York's Dental Affairs Committee that a health care service, upon review based on the information provided, is not medically necessary.
- C. Clinical Peer Reviewer shall mean a physician who possesses a current and valid non-restricted license to practice medicine or a health care professional other than a licensed physician who: (1) where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession, and (2) is in the same profession and same similar specialty as the Health Care Provider who typically manages the medical condition or disease or provides the Health Care Service or treatment under review.
- D. Clinical Standards shall mean those guidelines and standards set forth in the Utilization Review Plan by the Utilization Review Agent whose Adverse Determination is under appeal.
- E. External Appeal shall mean an appeal conducted by an External Appeal Agent pursuant to Section 4914 of the New York Insurance Law.
- F. External Appeal Agent shall mean an entity certified by the superintendent pursuant to Section 4911 of the New York Insurance Law.
- G. Final Adverse Determination shall mean an Adverse Determination which has been upheld by a Utilization Review Agent with respect to a proposed Health Care Service following a standard appeal, or an expedited appeal where applicable, pursuant to Section 4904 of the New York Insurance Law.
- H. Health Care Provider shall mean a Health Care Service or a facility licensed pursuant to Article 28, 36, or 47 of the Public Health Law or a facility licensed pursuant to Article 19, 23, 31, or 32 of the Mental Hygiene Law.

- I. Health Care Service shall mean: (1) for purposes of appeals requested pursuant to Paragraph two of Subsection b of Section 4910 of Title 2 the New York Insurance Law, Health Care Service shall mean experimental or investigational procedures, treatments or services, including services provided within a clinical trial, and the provision of a pharmaceutical product pursuant to prescription by the patient's attending physician for a use other than those uses for which such pharmaceutical product has been approved for marketing by the Federal Food and Drug Administration to the extent that coverage for such service is prohibited by law from being excluded under the plan, or (2) in all other cases, health care procedures, treatments or services provided by a facility licensed pursuant to Article 28, 36, 44, or 47 of the Public Health Law pursuant to Article 19, 23, 31, or 32 of the Mental Hygiene Law, or provided by a health care professional, and the provision of pharmaceutical products or services or durable medical equipment.
- J. Enrollee shall mean a person subject to Utilization Review.
- K. Utilization Review shall mean the review to determine whether a Health Care Service that has been provided is being provided or is proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such service, is medically necessary. None of the following shall be considered Utilization Review: (1) denials based on failure to obtain a Health Care Service from a designated or approved Health Care Provider as required under a contract, (2) where any determination is rendered pursuant to Subdivision 3(a) of Section 2807(c) of the Public Health Law, (3) the review of the appropriateness of the application of a particular coding to a patient, including the assignment of diagnosis and procedure, (4) any issues relating to the determination of the amount or extent of payment other than determinations to deny payment based on an Adverse Determination, and (5) any determination of any coverage issues other than whether a Health Care Service is or was medically necessary.
- L. Utilization Review Agent shall mean any insurer subject to Article 32 or 43 of the New York Insurance Law performing Utilization Review and any independent Utilization Review Agent performing Utilization Review under contract with such insurer.
- M. Utilization Review Plan shall mean: (1) a description of the process for developing the written clinical review criteria, (2) a description of the types of written clinical information which the plan might consider in its clinical review, including but not limited to a set of specific written clinical review criteria, (3) a description of practice guidelines and standards used by a Utilization Review Agent in carrying out a determination of medical necessity, (4) the procedures for scheduled review and evaluation of the

written clinical review criteria, and (5) a description of the qualifications and experience of the health care professionals who developed the criteria, who are responsible for periodic evaluation of the criteria and of the health care professionals or others who use the written clinical review criteria in the process of Utilization Review.

## II. Standard Claims & Appeals Procedure

- A. Claims for Benefits: In the case of a post-service claim<sup>2</sup> which has been denied on the basis that such service was not dentally necessary, Delta Dental shall notify the Enrollee and the attending dentist of its Adverse Determination in writing within a reasonable period of time, but not later than thirty (30) days after the claim is filed. However, this period may be extended one time by Delta Dental for up to fifteen (15) days, if necessary due to the failure of the Enrollee to submit the information necessary to decide the claim. If there is an extension, the Enrollee and the attending dentist shall be notified of the extension and the reason for the extension within the original thirty (30) day period. The notice of extension shall specifically describe the required information, and the Enrollee or the attending dentist shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specific information. The extension period (15 days) – within which a decision must be made by Delta Dental – will begin to run from the date on which the Enrollee's response is received by the plan (without regard to whether all of the requested information is provided) or, if earlier, the due date established by the plan for furnishing the requested information (at least 45 days).
- B. Reconsideration of Adverse Determination: In the event the Utilization Review of a claim results in an Adverse Determination, and this determination was made *without attempting to discuss such matter with the attending dentist who specifically recommended the health care service, procedure or treatment*, the attending dentist shall have the opportunity to request a reconsideration of the Adverse Determination. Such reconsideration shall be conducted by the attending dentist and the Clinical Peer Reviewer making the initial determination or a designated Clinical Peer Reviewer if the original Clinical Peer Reviewer cannot be available. If the Adverse Determination is upheld after reconsideration, Delta Dental shall

---

<sup>2</sup> Delta Dental does not condition receipt of a benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care. Additionally, Delta Dental does not conduct concurrent review relating to continued or extended health care services, or additional services for an insured undergoing a course of continued treatment.

notify the Enrollee of the Adverse Determination as provided below in Section III(A).

- C. Informal Inquiry Option: If a claim is denied in whole or in part, a Enrollee may make an informal inquiry regarding general program and eligibility questions by contacting Delta Dental via its toll-free number at 1-800-932-0783. Every caller has access to a supervisor if dissatisfied with the response.
  
- D. Non-emergency Appeals of Adverse Determination: In lieu of making an informal inquiry, a Enrollee or his or her attending dentist may choose to appeal the Adverse Determination. The Enrollee may do so within one hundred eighty (180) days, either by writing to Delta Dental or by calling Delta Dental at its toll-free number. Written acknowledgement of the filing of the appeal to the appealing party will be provided to the Enrollee and the attending dentist within fifteen (15) days of the filing of the appeal. The letter or oral request for appeal should state why the claim should not have been denied. Also any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. Both the Enrollee and the attending dentist are entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim.
  
- E. Notification of Information Necessary to Conduct the Appeal: If Delta Dental requires information necessary to conduct a standard internal appeal, Delta Dental shall notify the Enrollee and the attending dentist, in writing within fifteen (15) days of receipt of the appeal, to identify and request the necessary information. In the event that only a portion of such necessary information is received, Delta Dental shall request the missing information, in writing, within five (5) business days of receipt of the partial information.
  
- F. The Review: The review shall be conducted for Delta Dental by a Clinical Peer Reviewer who is neither the Clinical Peer Reviewer who made the claim denial that is the subject of the review, nor the subordinate of such individual. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination. If the review is of a claim denial based in whole or in part on a lack of dental necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the

Delta Dental dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta Dental dental consultant whose advice was obtained in connection with the denial of the claim whether or not the advice was relied upon in making the benefit determination is also available on request. In making the review, Delta Dental will not afford deference to the initial Adverse Determination. A clinical examination at Delta Dental's cost may be implemented, along with discussion among dentist consultants. At this point, the Enrollee may also request a hearing.

- G. Final Adverse Determination: Delta Dental shall make a Final Adverse Determination within thirty (30) days of the date the request for appeal is received. Delta Dental shall advise the Enrollee and the attending dentist of the Appeal Determination within two (2) days of the rendering of such determination. Notification of the Final Adverse Determination will be provided in accordance with Section III(B) below.
- H. Appeal to Delta Dental's Dental Affairs Committee: If in the opinion of the Enrollee or the attending dentist the matter warrants further consideration and the Enrollee chooses not to file an External Appeal pursuant to Section 4914 of the New York Insurance Article, the Enrollee or attending dentist should advise Delta Dental in writing as soon as possible. The matter shall be immediately referred to Delta Dental's Dental Affairs Committee. Delta Dental's Dental Affairs Committee, which contains at least one licensed dentist, will review the claim and either approve payment for the dental service or issue an Adverse Determination. If the Dental Affairs Committee requires information necessary to conduct the Internal Appeal, Delta Dental shall notify the Enrollee or attending dentist, in writing within fifteen (15) days of receipt of the appeal, to identify and request the necessary information. In the event that only a portion of such necessary information is received, Delta Dental shall request the missing information, in writing, within five (5) business days of receipt of the partial information. This stage can include a clinical examination, if not done previously, and a hearing before the Dental Affairs Committee if requested. The Dental Affairs Committee will render a decision within thirty (30) days of the request for further consideration. The decision of the Dental Affairs Committee shall be final insofar as Delta Dental is concerned. Recourse thereafter would be to the courts with an ERISA or other civil action or the filing of an External Appeal pursuant to Section 4914 of the New York Insurance Article, if the time period for doing so had not previously expired.

III. Distribution of Information to Enrollees/Attending Dentists Upon Entry of Adverse Determination

A. Content of Notification of Adverse Determination (See Exhibit A, attached hereto). A notice of an initial Adverse Determination will include:

1. The specific reason or reasons for the Adverse Determination including the clinical rationale, if any;
2. Reference to the specific plan provisions on which the Adverse Determination is based;
3. Instructions on how to initiate standard and expedited appeals including a description of the Delta Dental's review procedures and the time limits applicable to such procedures and a statement of the Enrollee's right to bring a civil action under Section 502(a) of ERISA upon completion of the second level of review of Delta Dental's Internal Appeals Procedure;
4. Instructions on how to initiate an External Appeal pursuant to Section 4914 of the New York Insurance Law;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Determination, a statement that a copy of such will be provided free of charge upon request;
6. If the Adverse Determination is based on dental necessity or experimental treatment or similar exclusion or limit, a statement that an explanation applying the terms of the plan to the Enrollee's medical circumstances is available upon request;
7. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

B. Content of Notification of Adverse Determination on Review i.e., "Final Adverse Determination." (See Exhibit B, attached hereto). If after the claim is reviewed, Delta Dental continues to deny the claim, Delta Dental shall send the Enrollee/attending dentist a notice, which contains:

1. A clear statement describing the basis and clinical rationale for the denial as applicable to the insured including the specific reason or reasons for the determination, reference to the specific plan provisions upon which the Adverse Determination is based;
2. A clear statement that the notice constitutes the Final Adverse Determination;
3. The insured's coverage type;
4. The name and full address of Delta Dental's Utilization Review Agent;
5. Delta Dental's contact person and his or her telephone number;
6. A description of the health care service that was denied, including the dates of the service, the name of the facility and/or physician proposed to provide the treatment and the developer/manufacturer of the health care service;
7. A statement that the Enrollee and the attending dentist may be eligible for an External Appeal and the time frames for requesting an appeal;
8. A clear statement written in bolded text that the forty-five (45) day time frame for requesting an External Appeal begins upon receipt of the Final Adverse Determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing the request a second level internal appeal, the time may expire for the Enrollee to request an External Appeal;
9. A copy of the standard description of the External Appeal process as developed jointly by the superintendent and commission, including a form and instructions for requesting an External Appeal;<sup>3</sup>

---

<sup>3</sup> Such information will also be provided by Delta Dental within three business days of a request by a Enrollee or an Enrollee's designee.

10. A statement that the Enrollee is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
11. A statement that when the Enrollee completes the second level of Delta Dental's Internal Appeals Procedure, the Enrollee will then have a right to bring an action under Section 502(a) of ERISA;
12. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Determination, a statement that a copy of such will be provided free of charge upon request;
13. If the Adverse Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation applying the terms of the plan to the Enrollee's medical circumstances is available upon request;
14. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

#### IV. Cooperation with the External Appeal Agent

Delta Dental will facilitate the prompt completion of External Appeal requests by:

- A. Transmitting the Enrollee's dental and treatment records pursuant to an appropriately completed release or release signed by the Enrollee or by a person authorized pursuant to law to consent to health care for the Enrollee and, in the case of dental necessity appeals, transmit the clinical standards used to determine medical necessity for the Health Care Service within three (3) business days of receiving notification regarding the identity and address of the certified External Appeal Agent to which the subject appeal is assigned.
- B. Providing information requested by the assigned certified External Appeal Agent as soon as is reasonably possible, but in no event shall

Delta Dental take longer than two (2) business days to provide the requested information.

- C. Providing the form and instructions, developed jointly by the superintendent and commissioner, for the attending dentist to request an External Appeal in connection with a retrospective adverse utilization review determination under Section 4904 of the Insurance Law, within three (3) business days of an attending dentist's request for a copy of the form.
- D. In the event that an Adverse Determination is overturned on External Appeal, or in the event that Delta Dental reverses a denial which is the subject of an External Appeal, Delta Dental shall make payment for the Health Care Service which is the basis of the External Appeal to the Enrollee.
- E. No fee will be charged by Delta Dental to a Enrollee for an External Appeal.

## **EXHIBIT A**

### **NOTICE OF ADVERSE DETERMINATION**

This notice, provided to you pursuant to the requirements of Article 49 of the New York Insurance Law and the United States Department of Labor Claims Procedure Regulations constitutes an Adverse Determination of your claim.

#### **Reasons for the Determination**

The NOTICE OF PAYMENT OR ACTION attached hereto outlines the specific reason(s) and the specific plan provision(s) on which the determination was based.

#### **Availability of Clinical Review Criteria Relied Upon to Make this Determination**

Upon request and free of charge, Delta Dental will provide to you a copy of any internal rule, guideline or protocol, and/or an explanation of the scientific or clinical judgment if relied upon in denying your claim.

#### **Instructions on How to Initiate a Standard Appeal & How to Initiate an External Appeal**

If you or your attending dentist want the denial of benefits reviewed, you or your attending dentist must contact Delta Dental, either in writing or by calling Delta Dental's toll-free number, 1-800-932-0783 *within one hundred eighty (180) days of the date on this notice. Failure to comply with such requirements may lead to forfeiture of your right to challenge this denial, even when a request for clarification has been made.* You should state why the claim should not have been denied. Also, any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. You or your attending dentist are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered initially.

The review shall be conducted for Delta Dental by a Clinical Peer Reviewer who is neither the Clinical Peer Reviewer who made the claim denial that is the subject of the review, nor the subordinate of such individual. If the review of a claim denial is based in whole or in part on a lack of dental necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such dental consultant. The identity of such dental consultant is available upon request whether or not the advice was relied upon. In making the review, Delta Dental will not afford deference to the initial Adverse Determination.

If after review, Delta Dental continues to deny the claim, Delta Dental shall notify you and your attending dentist in writing of the decision on the request for review within thirty (30) days of the date the request is received. Delta Dental shall send you and your attending dentist a notice, similar to this notice. If in the opinion of you or your attending dentist, the matter warrants *further* consideration, you have two choices: (1) you may continue to avail yourself of Delta Dental's Internal Appeals Procedure and eventually, upon completion of Delta Dental's second level of review, file an action in the courts pursuant to section 502(a) of ERISA; or (2) you may file an External Appeal with the New York Insurance Department. Attached hereto is "Standard Description and Instructions for Health Care Consumers to Request an External Appeal." More information on these two options will be provided to you after you complete the first level of review.

**Additional Necessary information which Must be Provided  
in Order for Delta Dental to Render a Decision on your Appeal**

If you should choose to avail yourself of Delta Dental's Internal Appeals Procedure, Delta Dental may require additional information in order to render a decision on your appeal. If this is the case, Delta Dental has attached to this notice a separate sheet containing of a list of such necessary information, which also explains why such material or information is necessary. Please submit such information to the address listed thereon. Please also include any other documents, data information or comments which you believe to have bearing on the claim including this denial notice.

**EXHIBIT B**

**NOTICE OF FINAL ADVERSE DETERMINATION**

This Notice is to inform you that upon review of your request for appeal of the Adverse Determination of your claim for benefits, **Delta Dental continues to deny your claim.** Attached are copies of the following: (1) a copy of the standard description of and instructions for initiating New York’s External Appeal process; and (2) an application form for requesting an External Appeal. Upon completion of the second level of Delta Dental’s Internal Appeals Procedure, you will then have a right to bring an action under Section 502(a) of ERISA.

**Please note that you or your attending dentist now have a right to file an External Appeal with the State of New York Insurance Department, but you must do so within forty-five (45) days from the date of your receipt of THIS NOTICE. Even though Delta Dental’s plan provides for two levels of review, the forty-five (45) day time period for requesting an External Appeal begins upon receipt of THIS NOTICE, the Final Adverse Determination of the first level appeal, regardless of whether or not a second level appeal is requested. By choosing to request a second level internal appeal, the time may expire for you to request an External Appeal.**

Additionally, you and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

**Availability of Clinical Review Criteria Relied Upon to Make this Determination**

*Upon request and free of charge, Delta Dental will provide to you a copy of any documents, records or other information relevant to your claim for benefits, as well as any internal rule, guideline or protocol, and/or an explanation of the scientific or clinical judgment if relied upon in denying your claim.*

1. Coverage Type: \_\_\_\_\_
  
2. Description of the Service for which payment was denied:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Basis and clinical rationale for the denial:

---

---

---

---

4. Specific criteria and standards, including interpretive guidelines on which the decision was based:

---

---

---

---

5. Plan provisions upon which the determination is based:

---

---

---

---

6. The following is the name, business address, and business telephone number of the Delta Dental representative who has responsibility for Delta Dental's Internal Appeals Procedure:

---

---

---

---

7. The following is the name, business address, and business telephone number of the Utilization Review Agent, if different from the answer provided in number 6, above:

---

---

---

---

By: \_\_\_\_\_  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_