



SUMMARY OF COVERAGE AND
CERTIFICATE OF BENEFITS

Wyoming State Employee's and Officials Group Dental Plan
Master Group #600



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Group Dental Insurance Plan

Policy Statement

THE STATE OF WYOMING (the Employer) has established an Employee Dental Insurance Plan. This booklet, effective January 1, 2017, replaces any prior Dental Plan booklet issued by Delta Dental.

The benefits described in this booklet constitute the benefits available under the State of Wyoming, Employees dental insurance plan. The plan will be maintained pursuant to the terms of this booklet. The dental insurance plan may be amended from time to time. All prior plan descriptions established or maintained by the Employer are hereby revoked.

The benefits that form the Diagnostic and Preventive AND the Voluntary Optional dental insurance plan as described in this booklet are self-funded by the Employer. The Plan Administrator has complete authority to control and manage the plan and has full discretion to determine eligibility, to interpret the policy and to determine whether a claim should be paid or denied, according to the provisions of the plan, as set forth in this booklet.

Definitions

Alternate benefit is a provision in a dental plan contract that allows the third-party payer to determine the benefit based on an alternative procedure that is generally less expensive than the one provided or proposed.

Amalgam is a silver material used to fill cavities that are placed on the tooth surface (that is used for chewing) because it is a particularly durable material.

Annual maximum benefit is the maximum benefit each member is eligible to receive for certain covered services in a coverage year. The annual maximum benefit is reached from claims settled under this handbook in a coverage year. This amount is shown on the summary of benefits sheet.

Apicoectomy is a surgical removal of the apex or tip of a root in order to remove diseased tissue.

Applicant wherever used in this Contract means the group that has requested a policy from Delta Dental.

Approved amount is the total amount that the dentist is permitted to collect as payment in full for the specified service. It includes the dental benefit plan's payment as well as the patient's deductible and/or co-insurance.

Benefits are services covered under a dental plan.

Billed Charge is the amount a dentist bills for a specific dental procedure.

Caries is a term that is used for tooth decay.

COBRA or Consolidated Omnibus Budget Reconciliation Act is a law that requires certain employers to offer continued health insurance coverage to eligible employees and/or their dependents who have had their health/dental insurance coverage terminated.

Co-insurance/cost sharing is the percentage of dental expenses you pay after the deductible is met, until you reach your annual maximum benefit.

Co-payment is a fixed dollar amount paid each time certain covered services are received.

Completion date is the date a procedure is completed. It is the insertion date for dentures and partial dentures. It is the cementation date (regardless of the type of cement used) for inlays, onlays, crowns, and fixed bridges.

Composite is a white resin material used to fill cavities which has less durability, thus it is placed on non-stress bearing surfaces of front teeth because the color more closely resembles the natural tooth than does the color of amalgam (Silver).

Contract means this agreement between Delta Dental and Applicant including the Application of the Applicant for this Contract and the attached appendices, endorsements and riders, if any. This Contract constitutes the entire Contract between the parties.

Contract Year means the twelve (12) month period commencing on the Effective Date and each yearly period thereafter.

Coverage percentage means the percentage of the maximum plan allowance paid by Delta Dental for a specific benefit, as specified in the summary of benefits.

Coverage year means the 12-month period over which a group's deductibles, maximums and other provisions apply. Also known as the benefit year. Your coverage year is shown on the summary of benefits sheet.

Crown is the artificial covering of a tooth with metal, porcelain or porcelain fused to metal and covers teeth that are weakened by decay or severely damaged or chipped.

Debridement is the removal of subgingival and/or supragingival plaque and calculus in order to complete an oral evaluation.

Deductible is the dollar amount you pay for covered services in a coverage year before benefits are available under this handbook. The family deductible is reached from deductible amounts paid on behalf of any combination of members.

Delta Dental means Delta Dental Plan of Wyoming, a non-profit dental service corporation, d.b.a. Delta Dental of Wyoming, acting for itself.

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

Dentures (complete/partial) replace missing permanent teeth with a removable set of artificial teeth.

Dependents are a subscriber's legal spouse as recognized by the State of Wyoming, and a child as defined below.

You will be required to provide documentation for any dependent you add to your coverage, i.e. birth certificate, marriage certificate. This applies regardless if you are adding them during open enrollment, new hire or due to a qualifying event or if they have been covered previously.

Child means:

- your natural child
- your step child
- your adopted child. This includes a child placed with you for adoption.

“Placed for Adoption” means the assumption and retention of a legal obligation for the total or partial support of a child in anticipation of the adoption of such child. The child’s placement is considered terminated upon the termination of such legal obligation.

- a child who is recognized under a medical child support order as having a right to enrollment under the Plan.
- A dependent child that the employee has been specifically appointed as permanent legal guardian.

A legal step child, adopted child, foster child, or any child you are legally responsible to provide for by virtue of a court order specifically naming you as the permanent responsible party will require copies of legal documents to be provided at the time you enroll eligible children. Statements concerning the legal responsibility for care cannot be made for limited purposes including but not limited to education and/or insurance purposes.

Eligible Employee means any employee who meets the conditions of eligibility outlined in the contract.

Eligible Person means an employee or a dependent who meets the conditions of eligibility outlined in the Contract.

Eligibility Date means the date an Employee’s eligibility for benefits becomes effective under the terms of this Contract.

Endodontist is a dentist with advanced training who specializes in diseases of the tooth pulp, performing such services as root canals.

Exclusion is a dental service or procedure not covered by a dental program.

Explanation of Benefits is a statement sheet that explains how your claim was processed, payment by Delta Dental, your responsibility, and other pertinent information.

Fluoride is a safe chemical compound that prevents cavities and makes the tooth surface stronger so that teeth can resist decay.

General Anesthesia is a patient induced state of unconsciousness determined by the provider to complete treatment.

General Dentist is a dentist who provides a full range of dental services for the entire family.

Grievance means any dissatisfaction with the administration, claims practices or provision of services by Delta Dental that is expressed in writing by or on behalf of an eligible person.

Group means the employer, association, union or other organization contracting with Delta Dental to provide benefits to its eligible employees or members and/or their dependents if applicable.

Health Insurance Portability and Accountability Act of 1996 is a federal law that requires all health plans, including health care clearinghouses and any dentist who transmits health information in an electronic transaction, to use a standard format. Providers' paper transactions are not subject to this requirement.

ID Number is the unique number assigned by the administrator of your dental plan or the Social Security number of the primary subscriber.

Implant is a material inserted or grafted into tissue. Dental implant is a device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing dental replacement.

Initial Enrollment Period means the initial period of time, as determined by the group and Delta Dental during which eligible employees may enroll eligible persons.

Insured the person to which this policy is issued.

Late Enrollee is a subscriber or dependent that does not enroll in the plan when initially eligible.

Limitations are restricting conditions - such as age, period of time covered, and waiting periods - under which a group or individual is insured.

Maximum Coverage Year Benefit is the maximum dollar amount a program will pay toward the cost of dental care incurred by an individual or family in a specified period, usually a calendar year.

Maximum Plan Allowance (MPA) is the amount that Delta Dental will pay for a service, supply, or dental procedure.

Medical Necessity/Dental Necessity means (effective July 1, 2010 Wyoming Statue 26-40-102) A medical/dental service, procedure or supply provided for the purpose of preventing, diagnosing or treating an illness, injury, disease or symptom.

- Is medically/dentally appropriate for the symptoms, diagnosis or treatment of the condition, illness, disease or injury; Provides for the diagnosis, direct care and treatment of the patient's condition, illness, disease or injury;
- Is in accordance with professional, evidence based medicine and recognized standards of good medical/dental practice and care; and
- Is not primarily for the convenience of the patient, doctor/dentist or other medical/dental provider.

A medical/dental service, procedure or supply shall not be excluded from being a medical/dental necessity under this section solely because the service, procedure or supply is not in common use if the safety and effectiveness of the service, procedure

or supply is supported by:

- Peer reviewed medical/dental literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE); or
- Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act.

Non-Participating Dentist is a state-licensed dentist who does not have a written participation agreement with Delta Dental.

Open Enrollment Period means an enrollment period after the initial enrollment period during which eligible persons may apply to become covered persons, and existing covered persons may apply to change to another coverage option, if available, or elect to terminate coverage.

Optional Treatment - Delta Dental will pay the pre-approved fee for the least expensive dental procedure that is equally effective. You will be responsible for the remainder of the dentist's fee if a more expensive dental procedure is selected.

Oral Surgeon is a dentist with advanced training who removes teeth, including impacted wisdom teeth, repairs fractures of the jaw and other damage to the bone structure around the mouth.

Orthodontics is the correction of misaligned teeth and jaw or the straightening of teeth. Also called braces.

Orthodontist is a dentist with advanced training who corrects misaligned teeth and jaws, usually by applying braces.

Participating Dentist is a licensed dentist who has signed a Delta Dental service agreement. Delta Dental's payment and the patient's payment, if any, are to be accepted by the contracting dentist as payment in full. Delta Dental's payment is sent directly to the contracting dentist. To find a participating dentist go to www.deltadentalwy.org. Click on "Find a Dentist". Then select "Delta Dental Premier" or "Delta Dental PPO" and enter your city or zip code.

Pediatric Dentist is a dentist with advanced training who generally limits his/her practice to children and teenagers. Also known as Pedodontist.

Periodontist is a dentist with advanced training who treats diseases of the gums.

Periodontal Scaling/Root Planing is the removal of hard deposits, with metal scalers and curettes, on the root surfaces. The intent is to remove the diseased elements of

the root surface, thereby permitting healing and potential reduction in depth of the periodontal pocket.

Preauthorization is the process by which Delta Dental determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Premium means amounts payable monthly by Applicant.

Prevailing Fee means the most commonly charged fee for a particular procedure in the geographic area or population center where covered dental services are provided, so long as it is not less than the average fee for such procedure. Such "Prevailing Fees" shall be kept current through analysis of fee data not less frequently than once every twelve (12) months.

Primary Insurance is the insurance carrier or third party payor that pays for services rendered to a covered person before any other carriers would.

Prophylaxis is a professional cleaning to remove plaque, tartar (calculus), and stain from teeth to help prevent dental disease.

Pulpotomy is a partial removal of the pulp.

Radiograph is the photographic representation of opaque objects produced by the action of ionizing radiation upon sensitized plate or film. Also known as x-ray or digital image.

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

Sealant is a thin plastic material used to cover the biting surface of a tooth to prevent tooth decay.

Secondary Insurance is the insurance carrier or third party payor that would process its payment for a claim after a primary carrier made payment, and make any additional payments as necessary.

Single Procedure means a dental procedure to which a separate procedure number has been assigned.

Space Maintainer is a mechanical or prosthetic device used to prevent the drifting of teeth in an area where there has been premature loss of a tooth or teeth.

Subscriber means an eligible employee or member of the group who (a) has completed and signed the documents necessary for coverage under the contract, (b) has been accepted by Delta Dental as a subscriber.

Summary of Benefits is a listing of the specific benefits and benefit limitations for dental services provided under the terms of your group's contract.

Treatment Plan is a written report prepared by a dentist showing the dentist's recommended treatment of any dental disease, defect, or injury.

Waiting Period is a period of time defined by the dental contract before benefits are covered.

Wisdom Tooth is the adult molar tooth, also called a third molar that is furthest back in the mouth. There are four third molars, two in the lower jaw and two in the upper jaw, one on each side.

X-ray is an image used for diagnosing oral health conditions that is produced by projecting small amounts of radiation on photographic film. Also called a radiograph or digital image.

Usual, Customary and Reasonable

USUAL - A "Usual" fee is that fee usually charged for a given service by an individual dentist to all his private patients, i.e., his own usual fee.

CUSTOMARY - A fee is "Customary" when it is within the range of usual fees charged by dentists of similar training and experience for the same service within that same specific and limited geographic area, as determined by Delta Dental.

REASONABLE - A fee is "Reasonable" when it meets the above two criteria and when it is justifiable considering the special circumstances of the particular case involved.

Participating Dentists

Participating dentists signed an agreement with Delta Dental and agree to abide by certain guidelines, such as not charging Delta Dental subscribers more than the pre-approved fees. This may result in savings. When you receive services from dentists who participate with Delta Dental of Wyoming or any other Delta Dental, all of the following statements apply:

- Participating dentists agree to file claims for you.
- Participating dentists do not charge the patient up front for any amount covered by Delta Dental except deductible and co-payment.
- Participating dentists will not charge back to the patient (balance bill) any amount over the amount allowable by Delta Dental.
- Claims are paid directly to participating dentists. You are responsible to pay your dentist for any deductible, coinsurance, or non-approved charge.
- Participating dentists may file a Preauthorization of Benefits when you have a treatment plan exceeding \$250.

Non-Participating Dentists

When you receive services from non-participating dentists, you will not receive any of the advantages that our agreement offers. As a result, when you receive services from non-participating dentists, all of the following statements apply:

- Non-participating dentists do not accept Delta Dental's pre-approved fees. This means you are responsible for any difference between their charge and what Delta Dental pays.
- Non-participating dentists are not responsible for filing your claims.
- Claims are paid to you. You are responsible for paying your dentist for claims as well as any deductible, coinsurance, or non-approved charge.
- Non-participating dentists do not agree to file Preauthorization of Benefits for you.

Delta Dental's Payment on Claims

Our policy is to send our payment for treatment after it is completed - not before. For example, we will send payment when:

- A crown is placed, not when it is cut.
- A fixed or removable prosthesis is placed.
- A root canal is filled.

Maximum Plan Allowance (MPA)

The maximum plan allowance is the amount that Delta Dental will pay for a service, supply, or dental procedure. The maximum plan allowance is established by Delta Dental of Wyoming and is developed from various sources, such as agreements with dentists, input from dental consultants, the simplicity or complexity of the procedure, and the charges for procedures by dentists in Wyoming.

For services billed by dentists outside of Wyoming, the maximum plan allowance is based on information from that state's Delta Dental.

Payment Procedures

- Delta Dental shall pay the following benefits upon the participating dentist's usual, customary and reasonable fee. The fee paid for any particular covered service shall be the lesser: a) the fee submitted on the Attending Dentist's Statement (claim form); or b) the maximum plan allowance, as determined by Delta Dental of Wyoming.
- The amounts payable by Delta Dental with respect to the services rendered by a Non-Participating Dentist shall not exceed the dentist's fees, or the non-participating maximum plan allowance, whichever shall be less.
- The amounts payable by Delta Dental with respect to services rendered by a dentist in another state or country who is not a Participating Dentist of Delta Dental in that state shall not exceed the amount that would be payable if such services had been provided by a Participating Dentist in Wyoming.
- The amounts payable by Delta Dental with respect to services rendered by a

dentist in another state who is a Participating Dentist of a Delta Dental Plan in that state shall be those that would be payable by that other Delta Dental Plan.

ELIGIBILITY

Eligible Employee means any official or employee of a covered entity who regularly works a minimum of 80 hours per calendar month and is a resident of the United States or Puerto Rico. Covered entities include, but are not limited to the State of Wyoming, the University of Wyoming, and the Wyoming Community Colleges.

- A. All employees become eligible for this Plan on the first day of the month following their date of employment. If you are a classified TP01 employee, the effective date is the first of the month after completion of 90 days.
- B. With respect to an employee who is covered under the Dental Plan and terminates employment, he or she may transfer employee coverage to his or her spouse who also is employed by a covered entity, if application is made within 60 days of termination. The effective date will be the first of the month after receipt of the application. If the family is covered under a split contract (both spouses employed by covered entity with covered children), the currently covered employee will automatically be changed to cover the family.
- C. If you are enrolled on the State Health Insurance Plan you must also be enrolled at a minimum in the Diagnostic & Preventive Dental Plan. If you are enrolled with single coverage for the State Health Plan you may elect either single or family dental coverage. If you are enrolled with family coverage for the State Health Plan, you must have family dental coverage.

Retiree means an Employee who:

- Has been retired from active service with the covered entity; and
- Has made application with the Employees' Group Insurance within 31 days of termination to continue coverage and
- Has had dental coverage in effect under the covered entity's plan for at least one year just prior to retirement; and either
 - Has attained at least age 50 on the date he/she retires; and just prior to the date of his/her retirement had completed at least 4 years of continuous service for the covered entity and is eligible for State of Wyoming Retirement Benefits/TIAA CREF; or
 - Is eligible for State of Wyoming Retirement Benefits/TIAA CREF; and just prior to the date of his/her initial retirement and completed at least 20 years of continuous service with covered entity.

Medicare eligible retirees may continue to keep the dental plan they are currently enrolled in (Diagnostic & Preventive only or Diagnostic & Preventive and Voluntary Plan) even if they cancel coverage under the State's Health Plan. Both the Medicare eligible retiree and their eligible dependents may continue the plan they are currently enrolled in (Diagnostic & Preventive only or Diagnostic & Preventive and Voluntary Plan) if they participated in the plan at the time that enrollment in the Health Plan is canceled. Medicare eligible retirees and their eligible dependents may not continue the Voluntary Optional Dental Plan if they are not also enrolled in the Diagnostic & Preventive Dental Plan.

Medicare eligible retiree's (eligible) dependents may not be enrolled in the Diagnostic & Preventive Dental Plan of the Voluntary Plan if the retiree is not enrolled in the same plan. Medicare eligible retirees who cancel their coverage in either Dental Plans **MAY NOT** re-enroll at a future date.

Dependents

Your dependents are eligible for coverage on the same date as you or the date they become eligible dependents, if you are insured as an employee. (a) If you enroll for dependent coverage on or before the date they become eligible, they will be covered on the 1st day of the month following the date they become eligible. (b) If you enroll for dependent coverage after they become eligible, but on or before the 60th day following the date they become eligible, they will become covered on the first day of the month coinciding with or next succeeding the date you enroll.

An eligible dependent is:

- Your legal spouse, as recognized by the State of Wyoming;
- Any child under the age of 26 (until the last day of the month the child turns 26; or if subject to guardianship, the end of the month the child turns 18).

The term "child" means your children. This includes any legal step-child, adopted child, foster child, or any child you are legally responsible to provide for by virtue of a court order specifically naming you as the permanent responsible party. Legal documents must be provided at the time you enroll eligible children in one of these categories. Statements concerning the legal responsibility for care cannot be made for limited purposes including but not limited to educational and/or insurance purposes.

The age limit does not apply to an enrolled child who becomes disabled, or became disabled before reaching the age limit and who cannot hold a self-supporting job due to a permanent physical handicap or mental handicap.

Any eligible dependent child who is not self-supporting due to developmental disabilities or physical disabilities must have been covered under the plan on the day before the date the child would otherwise lose dependent status due to reaching age 26.

"Physical handicap/mental handicap" means permanent physical or mental impairment that is a result of either a congenital or acquired illness or injury leading to the individual being incapable of independent living.

“Permanent physical or mental impairment” means a physiological condition, skeletal or motor deficit, or mental handicap or organic brain syndrome.

A non-permanent total disability where medical improvement is possible is not considered to be a “handicap” for the purpose of this provision. This includes substance abuse and non-permanent mental impairments.

At reasonable intervals, but not more often than annually, the plan may require a Doctor’s certificate as proof of child’s disability.

The plan will allow for a dependent child, if the employee has been appointed as permanent legal guardian.

Your dependent must live in the United States or Puerto Rico to be eligible for coverage.

A person who is covered under this Plan as an Employee may not be covered as both an “Employee” and a “Dependent.” A child may not be covered as a “Dependent” of more than one Employee.

Individuals where both husband and wife, “with eligible dependents”, are employed by covered entities are required to enroll in the Split Premium Arrangement if they are electing to cover themselves and any children. Spouses must choose the same benefits under the Split Premium Arrangement (i.e., Diagnostic & Preventive and Voluntary Optional plan).

If you did not apply for dependent coverage within 31 days of the date you became eligible because your dependents were covered under a group dental coverage plan sponsored by your spouse’s employer when you were initially eligible for dependent coverage under this contract, and such coverage is later terminated due to:

- Termination of your spouse’s employment; or
- Temporary lay-off or a labor strike, resulting in loss of dental benefits; or
- Termination of the other plan; or
- Significant change in benefits or premium that results in an additional cost of at least 35%;

When You Marry or Have Children - If you have no eligible dependents at the time you become covered under the Plan but later acquire them, be sure to enroll them promptly, within 60 days of their acquisition. A new spouse is eligible on your date of marriage. **It is necessary to enroll additional dependents even if you are already enrolled for dependent coverage.** To have continuous coverage from date of birth, newborns must be enrolled within 60 days of birth. Whenever you acquire eligible dependents, you must notify the Employee’s Group Insurance Agency and your Benefits Specialist and complete the appropriate form to cover them under the Plan.

Dependents of Deceased Employees/Retirees - If you die while an employee of the State of Wyoming, your dependents may continue the dental coverage(s) in effect at the time of your death. Your surviving spouse may continue coverage until remarriage, and surviving eligible children may continue coverage until spouse's marriage or reaching the limiting age described under "Dependents" in the section above.

Coverage Period

- A. If you enroll for coverage within 31 days of the date you become eligible, you will be covered beginning the first day of the month following your date of employment. If you are a classified TP01 employee, the effective date is the first of the month after completion of 90 days.
- B. Employees and/or dependents that waive or withdraw from the Voluntary Optional plan for any reason, will not be allowed to enroll or re-enroll until a three (3) year waiting period from the date the coverage was waived or withdrawn from has been met. Coverage would begin on January 1st following the three (3) year waiting period. There are two exceptions to this policy.

Exception 1:

Employees and dependents may apply to be enrolled in the Voluntary Optional Dental Plan prior to the three year waiting period if you submit a letter from your dentist that states neither you (the employee) nor your dependents (if applicable) are in need of any dental care based on examination. This statement must be submitted with the enrollment application. The Plan Administrator will make the final determination on whether you and your eligible dependents (if applicable) will be covered by the Voluntary Optional Dental Plan upon receipt of the information. Coverage becomes effective at the beginning of the month following approval by the Plan Administrator.

Exception 2:

Employees who enrolled eligible dependents for dependent coverage and later dropped that coverage because your dependents became covered under another group plan sponsored by your spouse's employer, and such coverage was later terminated under the same circumstances as set forth in Section III, "Dependents" on page 3, then you will be allowed to re-enroll your dependents for coverage without waiting the full three (3) years otherwise required under this plan, however you must apply for dependent coverage within 60 days of the date on which your spouse's coverage terminated under the group dental coverage plan sponsored by his/her employer.

- C. If you enroll more than 31 days after the date you become eligible, you must satisfy the dental plan eligibility requirements in order to be eligible for dental benefits. This applies to dependents also.

*An Eligible Employee becomes covered on the first day of the month following the Eligibility Waiting Period of continuous full-time employment and remains eligible for the effective contract period. If you are a classified TPO1 employee, the effective date is the first of the month after completion of 90 days.

Eligible Dependents, if enrolled, are eligible on the date the Employee's coverage is effective, or the date on which the Employee acquires the dependent, i.e. date of marriage.

Coverage for the Employee and/or Eligible Dependent shall terminate on the last day of the months in which: (1) the individual ceases to meet the definition of eligibility above, or (2) the required periodic premium is not received by Delta Dental from the covered group, whichever occurs first.

If you want to drop your dependent dental coverage, contact your Benefits Specialist and complete the appropriate form to drop dependent insurance. The form must be received by the end of the month in which you would like to terminate the coverage. Be aware, if you have elected to have your dental premiums deducted pre-tax you are not allowed to drop coverage without a qualifying event.

Coverage After Termination

If an Employee's employment and/or coverage terminates while he/she is receiving treatment under a predetermination or preauthorization of benefits which was approved while he/she was eligible for benefits, benefits will not continue to be paid for such approved treatment.

Terminated employees and their dependents may be entitled to an extension of Benefits under "COBRA" at the employee's expense. (Ask your employer for complete details of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or other State or Federal continuation of coverage statues and/or regulations.

BENEFITS

I. **Benefit Percentage**

Benefit Percentage is the percentage of allowable expenses that the Plan will pay for services rendered.

Diagnostic & Preventive Plan

For Diagnostic and Preventive Services.....**100%**

Diagnostic & Preventive Services are NOT subject to the deductible.

**If subscriber/employee has the Diagnostic & Preventive Plan along with the Voluntary Optional Plan the following benefit percentages and yearly maximums apply:*

Voluntary Optional Plan

For Diagnostic and Preventive Services.....**100%**
(not subject to the \$1,500 annual maximum or the deductible)

For Basic Services.....**80%**

For Major Services.....**50%**

Maximum Benefit per Person per Year (January-December).....**\$1,500.00**

Once an employee elects the Voluntary Optional Plan they are required to stay on the Voluntary Optional Plan for at least one (1) year.

II. **Deductible**

The Deductible is the amount of covered dental expenses which you pay before the dental benefits are payable, and applies to each covered person per calendar year. Deductibles apply only to those employees/subscribers opting the Voluntary Optional plan.

Deductible per Person.....**\$50**

Deductible per Family.....**\$100**

III. **Maximum Benefit**

Maximum Benefit is the total dollar amount that the Plan will pay for services rendered during any one year and applies to each covered person per calendar year. Delta Dental will reimburse participating dentists on a greater percentile than non-participating dentists.

Networks

State of Wyoming employees have two options for dental networks. Employees and their dependents can either 1) visit either a Premier participating dentist or 2) visit a PPO participating dentist. **If you visit a non-participating dentist, you will not receive any of the advantages of the Premier or PPO networks.**

Delta Dental Premier

The Delta Dental Premier allows you to visit any licensed, participating dentist.

Delta Dental Premier Dentists agree to abide by Delta Dental's determination of fees. When you visit a Delta Dental Premier dentist, we ensure that you pay no more than the co-insurance percentage identified on your Explanation of Benefits (EOB) which is defined by your group's coverage.

Delta Dental Premier is the nations and Wyoming's largest dental network.

Delta Dental PPO

Delta Dental PPO is our preferred provider organization plan.

With Delta Dental PPO, you have the flexibility to visit any licensed participating dentist. You'll enjoy lower out-of-pocket costs and your maximum will go farther when you select a Delta Dental PPO dentist because PPO dentists have agreed to accept reduced fees for covered procedures when treating PPO patients.

COVERED DENTAL SERVICES

Delta Dental will cover the following Services when they are rendered by a licensed dentist and when necessary and customary, as determined by the standards of generally accepted dental practice:

I. Diagnostic & Preventive Services

The necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment and to prevent the occurrence of oral disease.

- A. Routine periodic examinations, once every five months (not more than two per calendar year).

- B. Dental prophylaxis (cleaning) once every five months (not more than two per calendar year).

OR

Periodontal maintenance once every six months (not more than two per calendar year).

Benefit is for either a prophylaxis/cleaning or periodontal maintenance. subscribers cannot utilize both.

- C. Bitewing x-rays once every twelve months.
- D. Topical fluoride applications twice per year (through the end of the month in which age 18 is attained).
- E. Space maintainers, fixed.
- F. Sealants on posterior permanent bicuspid and molars once in a two year period (through the end of the month in which age 18 is attained).
- G. Full mouth x-rays once every twenty-four months.
- H. Emergency exam is a benefit once in a calendar year.

The following services are ONLY for employees/subscribers who have opted the
“Voluntary Optional Plan”:

II. Basic Services

- A. Oral Surgery: The necessary procedures for extractions and other oral surgery including pre-operative and post-operative care.
- B. Restorative Dentistry: The necessary procedures to provide amalgam, synthetic restorations, cast crowns, jackets, cast restorations, and preformed stainless steel crowns for treatment of carious lesions.
- C. Endodontics: The necessary procedures for pulpal therapy and root canal filling on non-vital teeth.
- D. Periodontics: The necessary procedures for treatment of the tissues supporting the teeth.
- E. Periodontal maintenance once every six months (not more than two per calendar year) coordinated with the periodontal maintenance performed under Diagnostic and Preventive services above.

III. Major Services

- A. Prosthodontics: The necessary procedures for repair or construction of bridges, partial and complete dentures. **These services have a six (6) month waiting period from the date of enrollment.**

1. Partial Dentures: Delta Dental will provide a standard chrome or acrylic partial denture or will allow the cost of such procedure toward a more complicated or precision appliance that patient and dentist may choose to use.
 2. Complete Dentures: If in the construction of a denture the patient and dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, Delta Dental will allow an appropriate amount for the standard denture toward such treatment and the patient must bear the difference in cost.
- B. Restorative Crowns & Onlays: The necessary procedures for provision of crowns, jackets or onlays (except stainless steel crowns which are covered under Basic Services). **ONLY payable when teeth cannot be restored with amalgam, composite resin or plastic materials due to extensive caries or fractures. An x-ray must accompany all claims for crowns. Crowns are not a benefit for cosmetic, attrition or preventive reasons.**
- C. Oral surgery: Natural tooth implants when accompanied by pre-operative and post-operative x-rays.
- D. Dental Implants: The necessary procedures for implants including the crown, bridge, or denture over the implant. Implants are payable at 50% with a \$1,000 annual maximum payment. In addition to the annual maximum there is to be a \$1,000 per tooth limit per sixty (60) month period. This includes the cost of the implant, maintenance, surgical removal thereof or the crown, bridge and denture over the implant. This benefit will be subject to the \$1,500 calendar year optional dental plan maximum. **This service has a six (6) month waiting period from the date of enrollment and is not a benefit until that period has lapsed.**

LIMITATIONS

The benefits as outlined in all Plans are subject to the following limitations:

- A. Diagnostic: Exams are a benefit once in a five (5) month period (not to exceed two in a calendar year) and bitewing x-rays are a benefit once in a twelve (12) month period. Full mouth x-rays are a benefit once in a twenty-four (24) month period. One emergency exam will be a benefit once in a calendar year.
- B. Preventive: Prophylaxis is a benefit once every five (5) months (not to exceed two in a calendar year). Periodontal maintenance is a benefit once every (6) six months (not to exceed two in a calendar year). **This benefit is for either a prophylaxis/cleaning or periodontal maintenance, subscribers cannot utilize both.**

- C. Topical fluoride applications for dependent children (through the end of the month in which age 18 is attained) are a benefit twice per calendar year. Space maintainers are a benefit for dependent children (through the end of the month in which age 18 is attained) only to maintain the space of primary teeth. Sealants for dependent children on permanent bicuspids and molars once in a two (2) year period (through the end of the month in which age 18 is attained).
- D. Prosthodontic appliances (including bridges, partial and complete dentures), cast crowns, jackets and cast restorations will be replaced only after five (5) years have elapsed following any prior placement of such appliances under any Delta Dental program. ***Prosthodontics have a six (6) month waiting period from the date of enrollment.***
- E. Interim (surgical or temporary) dentures are considered optional services and are **NOT** a benefit.
- F. Replacement will be made of an existing prosthodontics appliance only if it is unsatisfactory and cannot be made satisfactory.
- G. Porcelain or metallic inlays, veneers or facings on molars are considered optional, and as such, are not covered services.
- H. Fixed bridges and/or removable partials are not a benefit for children under age 16. An allowance will be made for a temporary acrylic partial for anterior/front teeth.
- I. A fixed bridge is not a covered service when done in connection with a removable partial denture in the same arch.
- J. Cast crowns, veneer crowns and jackets are not covered services for children under age 16. An allowance will be made for an acrylic crown or a preformed stainless steel crown.
- K. Reline or rebase of a denture is a benefit only twice in a five (5) year period.
- L. Implants are payable at 50% with a \$1,000 annual maximum payment. In addition to the annual maximum there is to be a \$1,000 per tooth limit per sixty (60) month period. This includes the cost of the implant, maintenance, surgical removal thereof or the crown, bridge and denture over the implant. This benefit will be subject to the \$1,500 calendar year optional dental plan maximum. **This service has a six (6) month waiting period from the date of enrollment and is not a benefit until that period has lapsed.**
- M. Prosthetic services utilizing full dentures, partial dentures, and removable appliances **have a six (6) month waiting period from the date of enrollment and is not a benefit until that period has lapsed.**

N. Optional services: In all cases in which the patient selects a more expensive plan of treatment than is customarily provided, Delta Dental will pay the applicable percentage of the lesser fee. The patient is responsible for the remainder of the dentist's fee. In the event the treatment of choice is NOT a benefit of the plan, the patient is responsible for the dentist's fee.

For example:

1. Partial Dentures: Delta Dental will provide a standard chrome of acrylic partial denture or will allow the cost of such procedure toward a more complicated or precision appliance that patient and dentist may choose to use.
2. Complete Dentures: If in the construction of a denture the patient and dentist decide on personalized restorations or employ specialized techniques as opposed to the standard procedures, Delta Dental will allow an appropriate amount for the standard denture toward such treatment and the patient must bear the difference in cost.
3. Occlusion: Delta Dental will allow an appropriate amount for the procedures necessary to replace missing teeth. Procedures, appliances or restorations necessary to increase vertical dimension and/or restore or maintain the occlusion are considered optional, and the cost is the responsibility of the patient. Such procedures include, but are not limited to, equilibration, periodontal splinting, restoration for tooth structure lost from attrition, restoration for malalignment of the teeth, and bite appliances (night guards or athletic mouth guards).

Services not Covered

The limitations and exclusions listed in this policy apply to all covered services described in this benefit document. Benefits will not be provided for any service not specifically listed as a covered service or will be limited as indicated. Call us at 307-632-3313 or 1-800-735-3379 if you are unsure if a certain service is covered.

Exclusions – *This handbook does not provide benefits for dental treatment listed in this section.*

Absence of coverage

Dental procedures, services, treatment and supplies for which the Covered Person would have no obligation to pay in the absence of this or any similar coverage.

Allergies

You are not covered for restorations or procedures necessary due to allergies or allergic reaction to dental treatment materials such as allergies to metals or mercury.

Anesthesia or analgesia

You are not covered for local anesthesia or nitrous oxide (relative analgesia) when billed separately from the related procedure. This exclusion does not apply to general anesthesia or intravenous sedation administered in connection with covered oral surgery as described in the benefits section of this policy.

Broken appointments

You are not covered for any fees charged by your dental office because of broken appointments.

Cleaning of prosthetic appliance

Your plan does not cover the cost of cleaning removable partials or dentures.

Charges for consultation

Charges for consultation are not a covered benefit.

Completion of form

Your plan does not cover any charges to complete forms.

Complete occlusal adjustment

You are not covered for services or supplies used for revision or alteration of the functional relationships between upper and lower teeth unless otherwise noted on the summary of benefits sheet at the front of this handbook.

Complications of a non-covered procedure

You are not covered for complications of a non-covered procedure.

Comprehensive Services

When two or more services are submitted and the services are considered part of the same service to one another, Delta Dental will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by Delta Dental.

Congenital deformities

You are not covered for services or supplies to correct congenital deformities, such as a cleft palate.

Controlled release device

You are not covered for services or supplies used for the controlled release of therapeutic agents into diseased crevices around your teeth.

Cosmetic in nature

You are not covered for services or supplies which have the primary purpose of improving the appearance of your teeth, rather than restoring or improving dental form or function.

Coverage commencing before the date the dental coverage starts.

Crowns, appliance and restorations

You are not covered for crowns that are not meant to restore form and function of a tooth, including crowns placed for the primary purpose of periodontal splinting, cosmetics, altering vertical dimension, restoring your bite (occlusion), or restoring a tooth due to allergies, attrition, abrasion, erosion and abfraction. Crowns placed on anterior teeth for endodontic purposes only are not a covered benefit.

Desensitization materials

You are not covered for desensitization materials or their application.

Diet planning

Diet planning or training in oral hygiene or preventive care.

Drugs

You are not covered for prescription, non-prescription drugs, medicines or therapeutic drug injections.

Duplicate dentures

Your plan does not cover any charges for the duplication of dentures.

Duplication of dental records

Your plan does not cover any charges for the duplication of dental records.

Effective date

You are not covered for services or supplies received before the effective date of coverage.

Experimental or investigative

You are not covered for services or supplies that are considered experimental, investigative or have a poor prognosis. Peer reviewed outcomes data from clinical trial, Food and Drug Administration regulatory status, and established governmental and professional guidelines will be used in this determination.

General anesthesia/sedation

General anesthesia and intravenous sedation are benefits only when provided in conjunction with covered oral surgery and when billed by the operating dentist.

Government programs

You are not covered for services or supplies when you are entitled to claim benefits from governmental programs (except Medicaid & the Children's Health Insurance Program).

Hospital

Charges for hospital services or hypnosis.

Incomplete services

You are not covered for dental services that have not been completed.

Indirect pulp caps

You are not covered for indirect pulp caps.

Infection control

You are not covered for separate charges for "*infection control*," which includes the costs for services and supplies associated with sterilization procedures. Participating dentists incorporate these costs into their normal fees and will not charge an additional fee for "*infection control*."

Injuries

Dental Procedures, services, treatment and supplies to treat injuries or diseases caused by riots or any form of civil disobedience, injuries sustained while committing a felony or engaging in an illegal occupation or injuries that are intentionally inflicted.

Lost or stolen appliances

You are not covered for services or supplies required to replace a lost or stolen dental appliance or charges for duplicate dentures.

Malformation

Dental or surgical procedures performed to correct developmental malformation or acquired malformation.

Medical or health plan

Dental procedures, services, treatment or supplies for which benefit is provided by a medical or health plan.

Medical services or supplies

You are not covered for services or supplies which are medical in nature, including but not limited to dental services performed in a hospital, surgical treatment centers, treatment of fractures and dislocations, treatment of cysts and malignancies, and accidental injuries or treatment rendered other than by a licensed dentist.

Military service

You are not covered for services or supplies which are required to treat an illness or injury received while you are on active status in the military services.

Motor vehicle injury

Dental Procedures, services, treatment and supplies for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.

Mutually exclusive service

When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), Delta Dental will pay for the service that represents the final treatment as determined by Delta Dental.

Night guard/occlusal guards/athletic guards

Your plan does not cover appliances for bruxism, grinding or clenching of teeth.

Not dentally necessary

Dental procedures, services, treatment and supplies which are not dentally necessary or which do not meet generally accepted standards of dental practice.

Oral hygiene instruction

Plaque control programs, oral hygiene instruction and dietary instructions.

Orthodontic appliances repair or replacement

Your plan does not cover for the repair or replacement of any orthodontic appliance under this contract.

Orthodontic services

Your plan does not cover orthodontic services.

Payment responsibility

You are not covered for services or supplies when someone else has the legal obligation to pay for your care, and when, in the absence of this contract, you would not be charged. This may include, but not limited to, treatment of injuries intentionally inflicted or sustained while committing a criminal act as a form of civil disobedience.

Periodontal appliances

You are not covered for services or supplies for periodontal appliances (bite guards) to reduce bite (occlusal) trauma due to tooth grinding or jaw clenching.

Periodontal splinting

You are not covered for services or supplies used for the primary purpose of reducing tooth mobility, including crown-type restorations.

Pre-diagnostic services

Pre-diagnostic services, oral pathology laboratory procedures, and diagnostic tests and examinations other than pulp vitality tests.

Preventive control programs

Preventive control programs are not a covered benefit.

Prosthesis

The replacement of a prosthesis which, in the Dental Consultants opinion, can be repaired or does not need repair. The replacement of a prosthesis within 5 years after it was first placed, except when the replacement is: (1) made necessary by the extraction of a functioning natural tooth which is replaced while covered under the policy and when the existing prosthesis cannot be made serviceable; or (2) for full or partial dentures which, while in the mouth, have been damaged beyond repair as a result of injury occurring while covered.

Provisional (temporary) crowns, bridges or dentures

You are not covered for services or supplies for provisional crowns, bridges or dentures.

Repair, replacement or duplication of orthodontic appliances

You are not covered for services or supplies required to repair, replace or duplicate any orthodontic appliance.

Same day services

When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), Delta Dental will pay for the service that represents the final treatment as determined by Delta Dental.

Sealants for primary teeth, wisdom teeth, or restored teeth

You are not covered for sealants for primary teeth, wisdom teeth, or teeth that have already been treated with a restoration. Coverage only applies to 1st and 2nd permanent molars, non-decayed, non-restored.

Sedation

Pre-medication, analgesia or conscious sedation.

Services provided in other than office setting

You are not covered for services provided in other than a dental office setting. This includes, but is not limited to, any hospital or surgical/treatment facility. This is limited to dentists fees, no facility charges are allowed.

Specialized services

You are not covered for specialized, personalized, elective materials and techniques or technology which are not reasonably necessary for the diagnosis or treatment of dental disease or dysfunction. Specialized services represent enhancements to other services and are considered optional. Includes, but not limited to, copings and precision attachments.

Splinting

The joining of teeth to support each other for periodontal reasons (stabilization) by crowns or other means. Splinting for stabilization due to an accident or injury is a covered benefit.

Sterilization

Sterilization preparation, infection control, operatory preparation and sepsis control are considered part of all procedures and are not a benefit.

Temporary or interim procedures

You are not covered for temporary or interim procedures.

Temporomandibular joint (TMJ) dysfunction

You are not covered for expenses incurred for diagnostic x-rays, appliances, restorations or surgery in connection with temporomandibular joint dysfunction or myofunctional therapy.

Termination

Whether or not we have approved a treatment plan, you are not covered for treatment received after you or your group's coverage termination date.

Treatment by other than a licensed dentist

You are not covered for services or treatment performed by other than a licensed dentist or his or her employees.

Workers' compensation

You are not covered for services or supplies that are or could have been compensated under Workers' Compensation laws, including services or supplies applied toward satisfaction of any deductible under your employer's Workers' Compensation coverage.

Other:

Any procedure which (1) is for the purpose of changing vertical dimension; or (2) relates to bite registration, bite analysis, or the correction of the bite; or (3) is for replacing tooth structure lost as a result of abrasion or attrition; or (4) is for equilibration or restorations for malalignment of the teeth; or (5) gnathologic recordings.

Services for which the covered person has or had a right to payment under a program of a government or plan established by law except; (a) Medicare; (b) Medicaid; (c) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and (d) where the law does not permit this type of exclusion.

Preauthorization of Benefits

A preauthorization of benefits tells you and your dentist what is covered and how much will be paid on your treatment plan. It also determines that services are dentally necessary and appropriate.

When to submit a treatment plan

After an examination, your dentist may recommend a treatment plan. If the plan involves crown(s), bridgework, dentures, or implants costing over \$250 ask your dentist to send the treatment plan with x-rays to Delta Dental. If your dentist is a non-participating dentist, you will need to send the treatment plan, x-rays and supporting information to the address below. Delta Dental will determine benefit coverage, what portion of the cost we will pay and what portion you will be responsible for. You and your dentist will receive a preauthorization of benefits form with this information on it. The preauthorization of benefits is valid for 120 days from the date issued, if you are still covered by your dental plan. Before you schedule

dental appointments, you and your dentist should discuss the amount to be paid by Delta Dental and your financial obligation for the proposed treatment.

Preauthorization of Benefits
Delta Dental of Wyoming
PO Box 29
Cheyenne, WY 82003

The treatment plan review

Once we receive the treatment plan and proper documentation, we will let your dentist know if the treatment plan is approved. We will take one of the following actions:

- accept it as submitted.
- recommend an alternative benefit.
- deny the treatment plan because:
 - the procedure is not a benefit under your policy;
 - you did not receive an evaluation after we asked you to; or
 - the procedure is not dentally necessary and appropriate.
 - you are no longer eligible for the services.

Appeal

If we deny a treatment plan, you or your dentist can resubmit it with additional documentation and ask us, in writing, to reconsider. If necessary, we will ask you to get an evaluation from another dentist. We will pay for the evaluation.

Please note: Although we may approve a treatment plan, we are not liable for the actual treatment you receive from your dentist.

Filing Claims

Once you receive dental services, we need to receive a claim to determine the amount of your benefits. The claim lets us know the services you received, when you received them, and from which dentist.

When to file your claim

After your procedure is completely finished, you should file a claim if your dentist has not filed one for you.

Reasons your claim may be denied

Even though a procedure may appear in the *Benefits* section of this policy, you should note that before you are eligible to receive benefits, we consider the following:

Is the procedure dentally necessary?

- The diagnosis is proper.
- The treatment is necessary to preserve or restore the form and the function of the tooth or teeth and the health of the gums, bone, and other tissues supporting the teeth.

Is the procedure dentally appropriate?

- The treatment is the most appropriate procedure for your individual circumstances.
- The treatment is consistent with professionally recognized standards of dental care and complies with criteria adopted by Delta Dental.
- The treatment does not cost more than alternative procedures that would be equally effective. **If you receive alternative services other than the least costly, you are responsible for paying the difference.**

Is the procedure subject to limitations or exclusions?

- Procedures that are not dentally necessary or appropriate.
- Procedures that are not covered by this policy. See *Services not Covered* section.
- Procedures that have limitations associated with them. See the *Benefits* section for a description of covered procedures and limitations associated with certain procedures.
- Procedures that have reached the annual maximum benefit. See the summary of benefits sheet at the beginning of this policy.
- Any difference between the charge and what Delta Dental allows. **Please note: This only applies if you receive services from a non-participating dentist.**

Delta Dental's reply

Within 45 days of receiving all necessary documentation, we will send you a written decision and indicate any action taken.

Reviewing records

If you would like copies of records relevant to your claim, contact us at the following address or call 1-800-735-3379. Please allow two business days for us to process your request.

Delta Dental of Wyoming
PO Box 29
Cheyenne, WY 82003

Coordination of Benefits

When there is a basis for a claim under this plan and another plan, this plan is a secondary plan, which has its benefits determined after those of the other plan, unless:

The other plan has rules coordinating its benefits with those of this plan; and

Both those rules and this plan's rules described in subparagraph (b) require that this plan's dental benefits be determined before those of the other plan.

This Plan determines its order of benefits using the first of the following rules, which applies.

- 1) Non-dependent/Dependent. The benefits of the Plan that covers the person as an employee or member are determined before those of the Plan that covers the person as a dependent of an employee or member.
- 2) Dependent Child/Parents Not Separated or Divorced. This Plan and another Plan cover the same child as a dependent of different persons, called “parents” except as stated below:
 - a. the benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in the calendar year; but
 - b. if both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent. However, if the other Plan does not have the rule described in (a) but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.
- 3) Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a. first, the Plan of the parent with custody of the child;
 - b. then, the Plan of the spouse of the parent with custody of the child; and
 - c. finally, the Plan of the parent not having custody of the child.
 - d. Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child’s health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent and the entities obligated to pay or provide benefits of the respective parents’ Plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to the benefits of the Plan that covers the person as an employee or member are determined before those of the Plan that covers the person as a dependent of an employee or member.
 - e. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of a child, and the entity obligated to pay or provide the Benefits of the Plan of that parent has actual knowledge of those terms, the Benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- 4) Active/Inactive Employee. The benefits of a Plan which cover a person as an employee who is neither laid off nor retired or as that employee's dependent(s) are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's dependent. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- 5) Continuation of Coverage.
 - a. If a person has continuation coverage under federal or state law and is also covered under another Plan, the following shall determine the order of benefits:
 1. First, the benefits of a Plan covering the employee or member, or dependent of an employee or member.
 2. Second, the benefits under the continuation coverage.
 - b. If the other Plan does not have the rule described in subparagraph (A), and if as a result, the Plans do not agree on the order of benefits, this paragraph (5) is ignored.
- 6) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee or member longer are determined before those of the Plan which covered that person for the shorter time. If a Covered Person is entitled to coverage under a group health care plan which primarily covers services or expenses other than dental care, and if the Covered Person first became eligible under the Plans on the same date, this Plan shall be the secondary payor for those services covered by both Plans.

Effect on the Benefits of This Plan

- 1) In accordance with order of benefit determination rules, this plan is a secondary plan as to one or more other plans. In that event, benefits of this plan may be reduced under this paragraph so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses.
- 2) Reduction in this plan's benefits. The benefits that would be payable under this plan in the absence of this COB provision will be reduced by the benefits payable for the total allowable Expenses in a claim determination period under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an expense incurred and a benefit payable.

When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

- 3) No rule in other plan. If the other plan does not have rules coordinating benefits with those of this plan, the benefits of the other plan are determined first.

Right to receive and release needed information

Delta Dental has the right to decide the facts it needs to apply these rules. Delta Dental may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply coordination of benefits rules. Medical and dental records remain confidential as provided by applicable state and federal law. Each person claiming benefits under this plan must give Delta Dental any facts it needs to process the claim.

Right of recovery

If the amount of the payments made by Delta Dental is more than it should have paid under coordination of benefits, it may recover the excess, at its option, from one or more of: (1) the persons it has paid or for whom it has paid; (2) insurance companies; or (3) other organizations. The “amount of payments made” includes the reasonable cash value of any benefits provided in the form of services.

Continued Coverage

Covered Persons in employer groups (“Qualified Beneficiaries”) are permitted to elect continuation of coverage under this Contract upon the occurrence of any of the following “Qualifying Events”:

- (a) If an employee:
 - (i) Termination of employment, voluntary or involuntary, except for reasons of gross misconduct; or
 - (ii) Reduction in hours to fewer than the minimum required to be an Eligible Employee under this Contract.
- (b) If a Dependent of an employee:
 - (A) The Covered Person ceases to be a Dependent; or
 - (B) Death of the employee; or
 - (C) Termination of the employee’s employment, except for reasons of gross misconduct; or
 - (D) Reduction in the employee’s hours to less than the minimum required to be eligible to purchase Dependent coverage under this Contract; or
 - (E) Employee becomes entitled to Medicaid; or

(F) Parents become divorced or legally separated.

The Group must provide notice to the Covered Person of the right to elect COBRA continuation coverage.

A Covered Person whose coverage is terminated due to divorce, legal separation or cessation of eligibility for coverage must provide the Group notice of such event within 60 days of its occurrence.

An election of continuation coverage must be made within 60 days beginning on the later of the date of the Qualifying Event or the date the Covered Person receives notice of election rights. The COBRA election by a Covered Person is deemed an election by all others who would lose coverage as a result of the same Qualifying Event unless otherwise specified in the election or the Qualified Beneficiary independently elects COBRA continuation coverage.

If election of COBRA continuation coverage is timely, the coverage begins on the date of the Qualifying Event and ends on the earlier of:

- (a) 18 months after the employee's employment termination or reduction in hours.
- (b) 29 months after the Qualifying Event for
 - (i) a Qualified Beneficiary who is determined to be disabled under the Social Security Act at any time during the first 60 days of COBRA coverage and who notifies the Group of such determination within the first 18 months of COBRA coverage; and for
 - (ii) any nondisabled Qualified Beneficiaries with respect to the same Qualifying Event.
- (c) For Qualified Beneficiaries other than the employee, 36 months after the date of the initial Qualifying Event for all other Qualifying Events.
- (d) The date on which the Qualified Beneficiary receiving continuation in coverage fails to make a timely payment of Premium. Delta Dental will not reinstate COBRA continuation coverage once terminated for nonpayment of Premium.
- (e) The date on which the Group ceases to offer this Contract to any of its employees or members.
- (f) The date on which coverage begins under another group dental plan, as applicable. However, a person who has elected COBRA continuation coverage and whose new plan contains a pre-existing limitation clause can maintain COBRA continuation coverage until all pre-existing limitations under the new plan are satisfied.

The first Premium must be paid to the Group within 45 days of the election of COBRA continuation coverage. Future Premium payments must be paid by the first day of each month.

In accordance with ERISA Section 602(3), premium for a qualified disabled person will be 150% of the single, family, or other applicable Rate for the coverage during months 19 through 29 of COBRA continuation coverage. The premium for all other COBRA continuation coverage will not exceed 102% of the Rate in effect for the Group during months one through 18, and will not exceed 102% of the Rate in effect for the Group during months 19 through 36, if applicable.

Qualified Medical Child Support Order (QMCSO)

If you have a dependent child and your employer receives a Medical Child Support Order recognizing the child's right to enroll in this benefit plan, your employer will promptly notify both you and the dependent that the order has been received. Your employer also will inform you and the dependent of the employer's procedures for determining whether the order is a Qualified Medical Child support Order.

Within a reasonable time after receiving the order, your employer will decide whether the court order is a qualified Medical Child Support Order and will notify you and the dependent of that determination.

Rights of Recovery (Subrogation)

Delta Dental has the right to recover claim payments made to you should you be compensated for damages by another party. (e.g. If you are in an accident and Delta Dental pays a claim for dental problems caused by the accident, we can request a refund from you if you receive compensation from the other party (or their insurance company) involved in the accident.)

Delta Dental's Liability

In no instance is Delta Dental liable for any conduct, including but not limited to tortuous conduct, negligence, or wrongful acts or omissions by any person, including but not limited to subscribers, dentists, dental assistants, dental hygienists, hospitals or hospital employees receiving or providing services. In no instance is Delta Dental liable for services of facilities that, for any reason, are unavailable to you.

Grievance Procedures

Delta Dental will attempt to resolve the grievance or benefits determination appeal through informal discussions, consultations or conferences and internal reviews (for medically/dentally necessary services). Delta Dental has a multi-step appeals process that includes up to two internal reviews and an external review of disputed claims. In the event that the grievance or appeal remains unresolved, the subscriber or covered dependent, or his/her representative has the right to request an external review (for medically/dentally necessary claims) or to appear before Delta Dental's Dental Care and Professional Review Committee to present written or oral information and to question the committee.

Internal review of a denial of claim

A Claimant has the right to an Internal Review of a Denial of Claim.

Our written notification of Denial of Claim will include an APPLICATION FOR INTERNAL REVIEW. Any Claimant who decides to appeal a Denial of Claim must complete this Application and return it to Delta Dental within the timeframe set out below. This Application allows the Claimant to apply for an Internal Review and, if certain additional requirements are met, **apply** for an Expedited Internal Review or an Expedited Internal Review/Expedited External Review.

All requests for external review must be accompanied by a filing fee of \$15 made payable by check or money order to the Wyoming State Treasurer.

A Claimant may file an Expedited Internal Review if:

1. The timeframe for the completion of a normal review would seriously jeopardize the Claimant's life or health or jeopardize the Claimant's ability to regain maximum function; or
2. The claim concerns a request for an admission, availability of care, continued stay or dental care service for which the Claimant received Emergency Services, but has not been discharged from a Facility.

A Claimant may file an Expedited Internal/Expedited External Review if:

1. The Claimant has a dental condition where the timeframe for completion of an Expedited Internal Review would seriously jeopardize the Claimant's life or health or would jeopardize the Claimant's ability to regain maximum function; or
2. The claim concerns a request for admission, availability of care, continued stay or dental care service for which the Claimant received Emergency Services, but has not yet been discharged from a Facility; AND
3. The basis of the Application request is a Denial of Claim.

A Claimant cannot request an Expedited External Review for Retrospective Denial of Claim.

The Claimant also has the right to a signed opinion of at least one (1) certified dental consultant who agrees with Our Denial of Claim and who is NOT Our employee.

The Claimant will need to complete the Application and mail it to the address below within (60) sixty days of the Claimant's receipt of the Application if requesting an:

1. Internal Review;
2. Expedited Internal Review; or
3. Expedited Internal/Expedited External Review, simultaneously.

Delta Dental of Wyoming
6234 Yellowstone Road
Cheyenne, WY 82009
Toll Free: 1-800-735-3379 * Fax Number: 307-632-7309

Along with the Application, the Claimant may submit any additional information that relates to the Denial of Claim.

We will notify the Claimant in writing of our decision within:

1. 15 days of receiving the completed Application for Internal Review; and
2. 72 hours of receiving the completed Application for an Expedited Internal Review or Expedited Internal/Expedited External Review.

If the claimant's application requests expedited internal/expedited external review:

We will immediately determine if the Claimant's request meets the reviewability requirements to apply simultaneously for both an Expedited Internal Review and an Expedited External Review as set out above. We will notify both the Claimant and the Commissioner of Our determination. If the Claimant does not agree with Our determination, then the Claimant may appeal Our decision directly to the Commissioner;

If it is determined by Us or by the Commissioner that the Claimant's request does meet the reviewability requirements, We will send a copy of that request along with the Claimant's \$15.00 filing fee to the Commissioner;

We will assign the request to an IRO approved by the Commissioner. We will provide to the assigned IRO, all documents and information upon which We relied in making the Denial of Claim.

The IRO will determine whether:

1. The Claimant is or was a covered person under Delta Dental's dental benefit plan at the time the provision of or payment for dental services, procedures or supplies was requested or provided;
2. The provision of or payment for dental services, procedures or supplies requested by the Claimant reasonably appears to be a covered service under the dental benefit plan, but the determination by Delta Dental is that the services, procedures or supplies are not Medically/Dentally Necessary and Appropriate;
3. The Claimant has provided to Delta Dental all the information and forms required to process an Expedited External Review, including the Authorization to Release Dental Records.

As expeditiously as the Claimant's dental condition or circumstances require, but in no event more than 72 hours after the date of receipt of the request for an Expedited External Review, the IRO will:

1. Make a decision to uphold or reverse the Denial of Claim; and
2. Notify the Claimant, Delta Dental and the Commissioner of the decision.

If the IRO's initial notification is verbal, then the IRO will also provide written confirmation of that notification within 48 hours of the verbal notification.

If the IRO finds that the claim should be paid, Delta Dental will immediately approve the covered benefit that was the subject of the denied claim.

External review

A Claimant may have the right to an External Review. Delta Dental bears the cost of the External Review.

A Claimant may have the right to an Expedited External Review if:

1. The timeframe for the completion of a normal review would seriously jeopardize the Claimant's life or health or jeopardize the Claimant's ability to regain maximum function; or
2. The claim concerns a request for an admission, availability of care, continued stay or dental care service for which the Claimant received Emergency Services, but have not been discharged from a Facility. The Claimant cannot request an Expedited External Review for Retrospective Denial of Claim.

To request an External Review, the Claimant will need to complete an application for external review form, which will accompany all Internal Review denials. The Claimant will need to mail the completed application to the address below within sixty (60) days of the Claimant's receipt of the Application if requesting an External Review or an Expedited External Review.

Delta Dental of Wyoming
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Immediately upon receiving the completed application for external review, We will send a copy of the Claimant's completed Application to the Commissioner and assign the request to an IRO approved by the Commissioner. We will provide to the assigned IRO, all documents and information upon which We relied in making the Denial of Claim.

The IRO will determine whether:

1. The Claimant is or was a covered person under Delta Dental's dental benefit plan at the time the provision of or payment for dental services, procedures or supplies was requested or provided;
2. The provision of or payment for dental services, procedures or supplies requested by the Claimant reasonably appears to be a covered service under the dental benefit plan, but the determination by Delta Dental is that the services, procedures or supplies are not Medical/Dental Necessary and Appropriate;
3. Delta Dental has denied the Claimant's request for the provision of or payment for dental services, procedures or supplies after having been given the opportunity to review Delta Dental's initial Denial of Claim one (1) or more times;

4. The Claimant has provided to Delta Dental all the information and forms required to process an External Review, including the Authorization To Release Dental Records.

Within five (5) days of receiving the Application, the IRO will notify the Claimant and Delta Dental in writing whether the documentation is complete and, if not, what information or documentation is missing. The Claimant may submit to the IRO in writing any additional documentation supporting the appeal in addition to any missing documentation required by the IRO.

The IRO will submit to Delta Dental any additional information that the Claimant's provides, which Delta Dental may use to reconsider the appeal at this juncture. If Delta Dental decides to reverse its prior Denial of Claim, it will immediately provide written notice to the Claimant, the IRO and the Commissioner and the External Appeal will be terminated.

Within forty-five (45) days after the date of receipt of the Application, the IRO will provide written notice to the Claimant, Delta Dental and the Commissioner of its decision to uphold or reverse Delta Dental's Denial of Claim.

If the IRO determines the claims should be paid, Delta Dental will notify the Claimant within five (5) days of the reversal of the Denial of Claim.

Expedited external review

The process for an Expedited External Review is as follows:

1. We immediately determine whether a Claimant's Application meets the following reviewability requirements:
 - The Claimant has a dental condition where the timeframe for completion of an External Review would seriously jeopardize the Claimant's life or health or would jeopardize the Claimant's ability to regain maximum function; or
 - The claim concerns a request for admission, availability of care, continued stay or dental care service for which the Claimant received Emergency Services, but has not yet been discharged from a Facility; AND
 - The claim was denied as not being Dentally Necessary or on a similar basis.

Our determination is sent to both the Claimant and the Commissioner. If the Claimant does not agree with Our determination, then the Claimant can appeal our decision directly to the Commissioner;

2. If it is determined by Us or by the Commissioner that the Application does meet the reviewability requirements, We will send a copy of that Application along with the filing fee to the Commissioner;

3. We assign the Application to an IRO approved by the Commissioner. We will provide to the assigned IRO, all documents and information upon which We relied in denying any and all claims which are the subject of the Denial of Claim.

The IRO will determine whether:

1. The Claimant is or was covered under Delta Dental's dental benefit plan at the time the provision of or payment for dental services, procedures or supplies was requested or provided;
2. The provision of or payment for dental services, procedures or supplies requested by the Claimant reasonably appears to be a covered service under the dental benefit plan, but the determination by Delta Dental is that the services, procedures or supplies are not Dentally Necessary and Appropriate;
3. The Claimant has provided to Delta Dental all the information and forms required to process an Expedited External Review, including the Authorization to Release Dental Records.

As expeditiously as the Claimant's dental condition or circumstances require, but in no event more than 72 hours after the date of receipt of the request for an Expedited External Review, the IRO will:

1. Make a decision to uphold or reverse the Denial of Claim; and
2. Notify the Claimant, Delta Dental and the Commissioner of the decision.

If the IRO's initial notification is verbal, then the IRO will also provide written confirmation of that notification within 48 hours of the verbal notification.

If the IRO finds that the claim should be paid, Delta Dental will immediately approve the covered benefit that was the subject of the Denial of Claim.

Notice of Privacy Practices

This section describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Confidentiality of your health care information

This notice is required by law to inform you of how Delta Dental protects the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as individually identifiable information regarding a patient's health care history, mental or physical condition or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Delta Dental receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We follow the privacy practices described in this notice and federal and state privacy requirements that apply to our administration of your benefits. Delta Dental reserves the right to change our privacy practice effective for all PHI maintained.

We will update this notice if there are material changes and redistribute it to you within 60 days of the change to our practices. We will also promptly post a revised notice on our website.

A copy may be requested anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Delta Dental program and will be informed on how to obtain a copy at least every three years.

Permitted uses and disclosures of your PHI

Uses and disclosures of your PHI for treatment, payment or health care operations

Your explicit authorization is not required to disclose information about yourself, or for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or plan sponsor to administer your benefits. As permitted by law, we may also disclose PHI to third party affiliates that perform services for Delta Dental to administer your benefits. As permitted by law, we may disclose PHI to third-party affiliates that perform services for Delta Dental to administer your benefits, and who have signed a contract agreeing to protect the confidentiality of your PHI, and have implemented privacy policies and procedures that comply with applicable federal and state law.

Some examples of disclosure and use for treatment, payment or operations include: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Some other examples are:

- Uses and/or disclosures of PHI in facilitating treatment. *For example, Delta Dental may use or disclose your PHI to determine eligibility for services requested by your provider.*
- Uses and/or disclosures of PHI for payment. *For example, Delta Dental may use and disclose your PHI to bill you or your plan sponsor.*
- Uses and/or disclosures of PHI for health care operations. *For example, Delta Dental may use and disclose your PHI to review the quality of care provided by our network of providers.*

Other permitted uses and disclosures without an authorization

We are permitted to disclose your PHI upon your request or to your authorized personal representative (with certain exceptions) when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with law, and when otherwise required by law. Delta Dental may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

Some other examples include: to notify or assist in notifying a family member, another person, or a personal representative of your condition; to assist in disaster relief efforts; to report victims of abuse, neglect or domestic violence to appropriate authorities; for organ donation purposes; to avert a serious threat to health or safety; for specialized government functions such as military and veterans activities; for workers' compensation purposes; and, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting, provided it does not contain genetic information. Information can also be de-identified or summarized so it cannot be traced to you and, in selected instances, for research purposes with the proper oversight.

Disclosures Delta Dental makes with your authorization

Delta Dental will not use or disclose your PHI without your prior written authorization unless permitted by law. You can later revoke that authorization, in writing, to stop the future use and disclosure.

The authorization will be obtained from you by Delta Dental or by a person requesting your PHI from Delta Dental.

Your rights regarding PHI

You have the right to request an inspection of and obtain a copy of your PHI.

You may access your PHI by contacting Delta Dental at the address at the bottom of this notice. You must include (1) your name, address, telephone number and identification number, and (2) the PHI you are requesting. Delta Dental may charge a reasonable fee for providing you copies of your PHI. Delta Dental will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or x-rays, is returned by Delta Dental to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Delta Dental does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact Delta Dental as noted below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI.

You have the right to ask that we limit how we use and disclose your PHI, however,

you may not restrict our legal or permitted uses and disclosures of PHI. While we will consider your request, we are not legally required to accept those requests that we cannot reasonably implement or comply with during an emergency. If we accept your request, we will put our understanding in writing.

You have the right to correct or update your PHI.

You may request to make an amendment of PHI we maintain about you. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI.

For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact our privacy officer as noted at the end of this notice if you have questions about amending your PHI.

You have the right to opt-out of Delta Dental using your PHI for fundraising and marketing.

Delta Dental does not use your PHI for either marketing or fundraising purposes. If we change our practice, we must give you the opportunity to opt-out. We may send you newsletters or information regarding your dental program.

You have the right to request or receive confidential communications from us by alternative means or at a different address.

Alternate or confidential communication is available if disclosure of your PHI to the address on file could endanger you. You may be required to provide us with a statement of possible danger, as well as specify a different address or another method of contact. Please make this request in writing to the address noted at the end of this notice.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

You have a right to an accounting of disclosures with some restrictions. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons, certain law enforcement purposes or disclosures made as part of a limited data set. Please contact us at the number at the end of this notice if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by e-mail.

A copy of this notice is posted on the Delta Dental website. You may also request an email copy or paper copy of this notice by calling our Customer Service department at 1-800-735-3379.

You have the right to be notified following a breach of unsecured protected health information.

Delta Dental will notify you in writing, at the address on file, if we discover we compromised the privacy of your PHI.

The following is included in this document as per Section 1557 of the Affordable Care Act (ACA):

Notice of Non-Discrimination

Delta Dental of Wyoming (DDWY) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. DDWY does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

DDWY provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Written information in other formats (large print, audio, accessible electronic formats, other formats)

DDWY provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the DDWY Compliance Department at 800-735-3379.

Language Assistance Services

ATTENTION: If you speak any of the languages below, language assistance services, free of charge, may be available to you. Contact 800-735-3379 or 307-632-3313.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-735-3379 or 307-632-3313.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-735-3379 or 307-632-3313.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-735-3379 or 307-632-3313.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-735-3379 or 307-632-3313.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-735-3379 or 307-632-3313.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-735-3379 or 307-632-3313まで、お電話にてご連絡ください。

D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1kl'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 800-735-3379 or 307-632-3313

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電800-735-3379 or 307-632-3313。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-735-3379 or 307-632-3313.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-735-3379 or 307-632-3313번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-735-3379 or 307-632-3313.

PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi 800-735-3379 or 307-632-3313.

ध्यान: दनुहोसः तपाइले नेपाल बोल्नुहुन्छ भने तपाइको निम्त भाषा सहायता सवाहरु नःशल्क रूपमा उपलब्ध छ । फोन गर्नुहोसर् 800-735-3379 or 307-632-3313

ચુના: જો તમે જરાતી બોલતા હો, તો િન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો 800-735-3379 or 307-632-3313.

فرمها می باشد. با 800-735-3379 or 307-632-3313 تماس بگیرید. توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت اریگان برای شما

THIS CERTIFICATE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE DENTAL PLAN. THE DENTAL PLAN CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.

Booklet Provided By:



6234 Yellowstone Rd * PO Box 29 * Cheyenne, WY 82003
307-632-3313 * 800-735-3379
www.deltadentalwy.org