

NTESS Dental Care Program (DCP) Benefit Summary

Revised: January 1, 2026

This Benefit Summary applies to Employees and Retirees, effective January 1, 2026. For more information on other benefit programs under the NTESS Health and Welfare Benefits Plan for Active Employees (the “Employee H&W Plan”), see the Employee H&W Plan Summary Plan Description and for post-employment benefit programs under the NTESS Post-Employment Health and Welfare Benefits Plan (the “Post-Employment H&W Plan”), see the Post-Employment H&W Plan Summary Plan Description.

The Dental Care Program is maintained at the discretion of NTESS and is not intended to create a contract of employment and does not change the at will employment relationship between you and NTESS. The NTESS Board of Managers (or designated representative) reserves the right to amend (in writing) any or all provisions of the Employee H&W Plan and the Post-Employment H&W Plan (the “Plans”), and to terminate (in writing) the Plans at any time without prior notice, subject to applicable collective bargaining agreements.

The terms of the Plans cannot be modified by written or oral statements to You from human resources representatives or other NTESS personnel.



U.S. DEPARTMENT OF
ENERGY



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1. INTRODUCTION

This is a summary of highlights of the Dental Care Program (DCP), a component of the NTESS Health and Welfare Benefits Plan for Active Employees (the “Employee H&W Plan”) (ERISA Plan 540) and the NTESS Post-Employment Health and Welfare Benefits Plan (the “Post-Employment H&W Plan”) (ERISA Plan 545). This Benefit Summary is part of the Employee H&W Plan Summary Plan Description and Post-Employment H&W Plan Summary Plan Description. It contains important information about Your NTESS or “Sandia” health benefits.

Certain capitalized words in this Benefit Summary have special meaning. These words have been defined in Definitions.

When the words “we”, “us”, and “our” are used in this document, we are referring to the Company. When the words “You” and “Your” are used throughout this document, we are referring to people who are Covered Members as defined in Definitions.

Many sections of this Benefit Summary are related to other sections of the Benefit Summary and to information contained in the Employee H&W Plan Summary Plan Description and Post-Employment H&W Plan Summary Plan Description. You will not have all of the information You need by reading just one section of just one document.

Refer to the Employee H&W Plan Summary Plan Description or Post-Employment H&W Plan Summary Plan Description for information about eligibility, enrollment, disenrollment, premiums, termination, coordination of benefits, subrogation and reimbursement rights, when coverage ends, continuation of coverage provisions, and Your rights under the Employee Retirement Income Security Act of 1974 (ERISA).

To receive a paper copy of this Benefit Summary, other Benefit Summaries, the Employee H&W Plan Summary Plan Description or Post-Employment H&W Plan Summary Plan Description contact Sandia HR Solutions at 505-284-4700. These documents are also available on hr.sandia.gov.

Since these documents will continue to be updated, we recommend that You check back on a regular basis for the most recent version.

Note: Class II Dependents are not eligible for the NTESS DCP.

2. ACCESSING CARE

2.1. Dental Care Program Provider Networks

- The DCP Provider networks, which are considered “in-network”, are Delta Dental PPO™ and Delta Dental Premier®.
- You will receive the best cost savings when You receive services from a Delta Dental PPO Provider. These Providers offer services subject to lower Maximum Approved Fees.
- Your out-of-pocket costs will be higher for services from a Delta Dental Premier Provider. These Providers have agreed to higher Maximum Approved Fees.
- Your out-of-pocket costs will be highest for services from an out-of-network Provider; therefore, it is important to receive services from in-network Providers whenever possible.
 - Delta Dental Dentists will not bill a Delta Dental patient for any amount over the Delta Dental Maximum Approved Fee applicable to the service provided. The network Provider agreements with Delta Dental protect You from unexpected “balance bill” charges.
 - In-network Dentists (PPO and Premier) have agreed to bill Delta Dental, avoiding the need for You to pay first and wait for reimbursement. For covered services, You are responsible only for the Coinsurance amount and Deductibles, if any, until the maximum benefit amount has been reached for the plan year.
 - You have direct access to Delta Dental Dentists. Availability and appointment scheduling is always independently determined by each individual Dentist, not by Delta Dental.
 - Pre-selection of a Dentist is never required. Each member of the family may use a different Dentist, and You can change Dentists at any time.
- The patient’s share of the cost for any covered service depends on whether the Dentist is classified as in-network and, if a Delta Dental Dentist, whether or not the Dentist participates in the Delta Dental PPO network or the Delta Dental Premier network. Delta Dental has more than one Provider network available to employer groups.
 - Delta Dental Premier is a national Provider network, with Dentists in every state. This network is designed to provide the broadest selection of Dentists and dental specialists. Approximately three out of every four Dentists in the country participate.
 - Delta Dental PPO is a second, smaller national network, which is structured to provide additional cost savings, also with Dentists in every state.
- The Dental Care Program is a Delta Dental PPO Plus Premier plan, and services received from any Dentist in those two networks are considered in-network. Although the benefit levels are the same for each network, Your out-of-pocket costs will, generally, be significantly reduced when services are received from a Delta Dental PPO Dentist. Delta Dental PPO Dentists agree to accept lower Maximum Approved Fees, which reduce the cost of care, as compared to Dentists who participate in Delta Dental Premier network.

2.2. Non-Participating Dentists

Non-Participating Dentists are Dentists who do not participate in any Delta Dental Dentist network. Benefits apply for covered services received from a Non-Participating Dentist as shown in Benefit Program Coverage; however:

1. These Dentists are not subject to agreements that would require them to honor Delta Dental pricing maximums for covered services;
2. Benefit payments for covered services received from a Non-Participating Dentist are subject to Delta Dental fee maximums; but Non-Participating Dentists may bill their patients up to the full amount of their submitted charges;
3. Non-Participating Dentists are not subject to other member protections, such as guarantees on restorative services, which are required of Dentists who participate with Delta Dental;
4. Payments made by Delta Dental for services received from a Non-Participating Provider may be paid to the Provider or directly to the enrolled Subscriber, depending on the state in which the services were received and whether there was a valid Assignment of Benefits. You may be responsible for payment at the time services are received for the full amount due if required by the Non-Participating Provider. You can maximize benefits by selecting, whenever possible, an in-network Delta Dental Dentist.

For online access to Delta Dental PPO or Delta Dental Premier Provider directories, or to search for a Dentist nationally, visit the Delta Dental website at www.deltadentalnm.com.

For assistance, You may also call the Delta Dental Customer Service Department at 800-264-2818.

If You have limited access to Delta Dental network providers based on Your residential address, NTESS determines who will be placed in an Out-of-Area Plan based on residential zip code and re-evaluates access each calendar year.

2.3. Accessing Benefits

To use the DCP benefits, follow these steps:

- Read Your Dental Care Program (includes this Benefit Summary and the Employee H&W Plan Summary Plan Description or the Post-Employment H&W Plan Summary Plan Description) carefully to become familiar with the provisions and operations of this Program.
- Whenever possible, select a Participating Provider. Make a dental appointment and tell the dental office that dental coverage is under the NTESS Dental Care Program with Delta Dental of New Mexico. If the office is not familiar with the coverage applicable to the NTESS DCP or has any questions regarding the coverage, the dental office may contact the Delta Dental Customer Service Department at 800-264-2818.

Following dental treatment, a claim needs to be filed with Delta Dental. All Participating Delta Dental Dentist offices will file the claim directly with Delta Dental. Non-Participating Dentists may require patients to file their own claims.

2.4. Out-of-Pocket Expenses

The coverage is designed for cost sharing between You and the DCP for the services provided by a dental Provider.

Deductible – The DCP requires You to pay a portion of the initial expense toward some covered services in each Benefit Period. You are responsible for a \$50 Deductible each calendar year for services other than diagnostic and preventive. The family maximum Deductible is \$150 per calendar year.

Patient Portion – The patient is responsible for a percentage of covered services at the Co-insurance amount as shown in Benefit Program Coverage. The patient is responsible for payment to

the Dental Provider. The patient portion will vary depending on the level of benefits for the particular dental treatment, and on the selection of a Delta Dental PPO network Provider, a Delta Dental Premier network Provider, or a Non- Participating Provider.

Maximum Benefit Amount – The DCP will pay for covered services up to a maximum amount each calendar year for non-orthodontic services. Plan includes Preventive Care Security (PCS): Diagnostic and Preventive services do not count towards the Maximum Benefit Amount when services are rendered by in-network providers. PCS does not apply when services are received from out-of-network providers. The DCP will pay a separate maximum benefit amount per lifetime for orthodontic services. You are responsible for payment amounts due for any dental services that exceed the maximum benefit applicable in the Benefit Period.

2.5. Pre-Treatment Estimate

Pre-Treatment Estimate is not required as a condition for payment of benefits; however, if expensive or extensive dental work is needed, Delta Dental recommends that a Pre-Treatment Estimate be obtained prior to the services being performed. A Pre-Treatment Estimate provides both the patient and the Dentist with an estimate of the benefit levels, maximums, and limitations that may apply to a proposed treatment plan. Most importantly, Your share of the cost will be estimated.

Dental offices are very familiar with the Pre-Treatment Estimate procedures and will gladly provide this service to their patients.

A Pre-Treatment Estimate is not a guarantee of payment. Payment of benefits is subject to DCP provisions and eligibility at the time the service is actually provided.

Although a Pre-Treatment Estimate is not required as a condition for payment of benefits, Delta Dental offers a non-ERISA appeals process for Pre-Treatment Estimate. Refer to How to File an Appeal, for more information about appeal procedures.

2.6. Optional Services

To help control costs, Optional Services may apply to dental care services beyond treatment that is considered the standard of dental care customarily provided, or which are not necessary to restore function. This is the substitution of the benefit amount that would have been applicable for the customary or standard procedure and You will be responsible for any difference between the cost of the treatment received and the benefit payable.

As the claims administrator, Delta Dental makes all determinations about when to apply an Optional Service. A determination to apply an Optional Service is not an opinion or judgment on the quality or durability of the service received.

Pre-Treatment Estimate, which is an advance estimate of benefits payable under the DCP, is available when requested by the dental Provider prior to performing a recommended treatment for You.

2.7. Clinical Reviews

- All claims are subject to review by a licensed Dental Consultant. Payment of benefits may require that You be examined by a licensed Dental Consultant or an independent licensed Dentist.

- Delta Dental may require additional information prior to approving a claim. All information and records acquired by Delta Dental will be kept confidential.

2.8. Extension of Benefits Provision

Under the Extension of Benefits Provision, the DCP will provide benefits after coverage stops for the following services:

Service	Only if the Dentist...
Prosthetic Devices (such as a full or partial denture)	Took the impressions and prepared the abutment teeth while the patient was covered by the DCP, and Delivers and installs the device within two calendar months after coverage stops.
Crowns	Prepared the tooth for the crown while the patient was covered by the DCP, and Installs the crown within two calendar months after coverage stops.
Root Canal Therapy	Opened the tooth while the patient was covered by the DCP, and Completed the treatment within two calendar months after coverage stops.

3. BENEFIT PROGRAM COVERAGE

The schedule in **Appendix A** details the benefits levels applicable under the DCP for each network and plan. The percentage is based on the Dentist's submitted fees or the network-specific Maximum Approved Fees, whichever is lower. Non-Participating Providers bill patients for amounts above the Delta Dental Maximum Approved Fees. A dental service will be considered for benefits based on the date the service is completed. Benefits are subject to processing policies of Delta Dental.

Maximum Benefit Amounts: The Maximum Amounts vary by plan. Please refer to Appendix A for more information. Plans include Preventive Care Security (PCS); Diagnostic and Preventive services do not count towards the Maximum Benefit Amount when services are rendered by in-network providers. PCS does not apply to Diagnostic and Preventive services rendered by out-of-network providers.

Deductible: \$50 per DCP participant per Benefit Period limited to a maximum Deductible of \$150 per family. Deductible does not apply towards Diagnostic and Preventive Services or Orthodontic Services.

Sandia Retirees (PreMedicare and Medicare), Surviving Spouses and LTD Terminées are eligible for coverage under the retiree plan, which has the same benefits as the Standard Plan. For details regarding eligibility and enrollment, please contact Businessolver at 1-833-726-3421 or visit snlretireebenefits.com. Eligible retirees who are not Medicare eligible upon retirement will have the following options at the time of retirement:

- If enrolled in a dental plan, the retiree will be defaulted into the Sandia retiree dental plan at the time of retirement.
- Waive dental coverage offered to retirees.
 - All changes must be completed within 31 days of the date of retirement by contacting Businessolver at 1-833-726-3421 or snlretireebenefits.com.
 - Retirees can choose to drop covered dependents, but may not add dependents, at the time of retirement.
 - Retirees will only be able to add dependents or change medical/dental plan options at the next annual open enrollment after retirement.

4. DIAGNOSTIC AND PREVENTIVE SERVICES

Diagnostic: procedures to aid the Dentist in choosing required dental treatment (patient screenings, oral examinations, diagnostic consultations, brush biopsy, clinical oral evaluations, and radiographic images).

Palliative: minor treatment to relieve emergency pain.

Preventive: routine cleanings, application of fluoride, space maintainers and sealants.

4.1. Limitations on Diagnostic and Preventive Services

- Benefits for oral examinations, including diagnostic consultations, emergency or re-evaluation exams and clinical oral evaluations are limited as shown in Benefit Program Coverage.
- Dependents under the age of fourteen (14) are limited to routine child cleanings. Dependents age fourteen (14) and over will be considered adults for the purpose of determining benefits for cleanings.
- Two (2) routine prophylaxes (cleanings), and/or up to four (4) periodontal maintenance, or a full mouth debridement are payable per calendar year, not to exceed a total of four procedures in any calendar year. For example, a member can have one of the following combinations:
 - Two (2) routine prophylaxes (cleanings), or
 - One (1) routine prophylaxes (cleanings) and one (1) full mouth debridement.

For members with a history of periodontal disease:

- Two (2) routine prophylaxes (cleanings) and two (2) periodontal maintenance, or
- Four (4) periodontal maintenance
- Full-mouth debridement is a benefit once per lifetime and is considered one of the two routine prophylaxes (cleanings). An allowance will be provided for a routine cleaning if more than one full mouth debridement is provided and will be subject to the limitation for cleanings as shown in Benefit Program Coverage. The member is responsible for the difference in cost between the routine prophylaxes (cleanings) allowance and the approved fee for the full mouth debridement.
- A panoramic radiographic image with or without bitewing images is considered a complete series of radiographic images. Images exceeding the diagnostic equivalent of a complete series of radiographic images are not billable to the patient when taken on the same date of service.
- X-rays exceeding the diagnostic equivalent of a complete series are not billable to the patient when taken on the same date of service.
- Bitewing X-rays exceeding the diagnostic equivalent of a complete set of bitewings, are not billable to the patient when taken on the same date of service.
- Topical fluoride treatments are payable twice per calendar year for people up to age 19. Topical fluoride treatments are payable once per calendar year for people aged 19 and older, but only when medically necessary.

- Emergency palliative treatment does not include services and supplies that exceed the minor treatment of pain. Benefit is limited to radiographic images and tests necessary to diagnose the emergency condition.
- Benefits for the detection of oral cancer are limited to brush biopsy procedure and related laboratory analyses.
- Services for diagnostic casts, oral/facial photographic images, laboratory and diagnostic tests, non-routine diagnostic imaging, non-surgical collection of specimens, oral hygiene instruction, home fluoride, mounted case analysis, and nutrition or tobacco counseling are not covered.
- A separate fee for pulp vitality tests is a benefit only in conjunction with an emergency exam or palliative treatment on the same date of service.
- Benefits for sealants are limited to permanent molars free from occlusal restorations.
- A separate fee for the replacement of a sealant by the same Provider is not allowed within twenty-four (24) months of the initial placement.
- Benefits for space maintainers are limited to once per lifetime per site.
- A separate fee for the recementation or repair to a space maintainer by the same Provider is not allowed within six (6) months of the original treatment. Six (6) months after the original treatment date, recementation or repair is a benefit once per twelve (12) month period.
- A separate fee for the removal of a space maintainer by the same Provider who placed the initial appliance is not allowed.

Refer to General Limitations and Exclusions, for additional provisions that may apply.

5. RESTORATIVE SERVICES

Restorative services are amalgam, resin-based composite restorations (fillings), stainless steel and prefabricated stainless-steel restorations. These covered services are a benefit for the treatment of visible destruction of the hard tooth structure resulting from the process of decay or breakage.

Limitations on Restorative Services

- A separate fee for the replacement of a restoration or any component of a restoration on a tooth for the same surface by the same Provider is not allowed if done within twenty-four months of the initial service.
- When multiple restorations involving multiple surfaces of the same tooth are performed on a posterior tooth, benefits will be limited to that of a multi-surface restoration. A separate benefit may be allowed for a non-contiguous restoration on the buccal (cheek side) or lingual (tongue side) surface(s) of the same tooth subject to clinical review.
- Amalgam or composite resin restorations are covered services on all teeth. Prefabricated resin crowns are a benefit for primary anterior (front of the mouth) teeth only.
- Preventive restorations are not a covered benefit.
- Services for metallic, porcelain/ceramic, or composite/resin inlays are limited to the benefit for the equivalent amalgam/resin procedure.
- Replacement of existing restorations (fillings) for any purposes other than treating active tooth decay or fracture is not covered.
- Separate fees for more than one pin per tooth or a pin performed on the same date of service as a build-up are not allowed. Pin retention, when dentally necessary, is allowed once per tooth in a twenty-four (24) month period.

Refer to General Limitations and Exclusions, for additional provisions that may apply.

6. BASIC SERVICES

Anesthesia: intravenous sedation and general anesthesia.

Endodontics: the treatment of dental pulp and surgical procedures involving the root.

Extractions: surgical and non-surgical extractions.

Oral Surgery: oral surgery including oral maxillofacial surgical procedures of all hard and soft tissue of the oral cavity.

Periodontics: treatment of disease of the gums and supporting structures of the teeth. For purposes of benefit calculation, a quadrant is defined as four (4) teeth. Periodontal maintenance is considered to be a periodontal cleaning for benefit determination or payment purposes.

6.1. Limitations on Basic Services

- Intravenous (IV) sedation and general anesthesia are not benefits for non-surgical extractions and/or patient apprehension.
- IV sedation and general anesthesia are benefits only when administered by a licensed Dentist in conjunction with specified surgical procedures, subject to clinical review and when medically necessary.
- Benefits for pulpal therapy procedure are limited to once in a twenty-four (24) month period.
- A separate fee is not allowed for pulpal therapy procedures when performed on the same day, by the same Provider, as other surgical procedures involving the root.
- A separate fee is not allowed for a pulp cap placed on the same day as a restoration or within twenty-four (24) months of a pulp cap placed on the same tooth by the same Provider.
- A pulpotomy or pulpal debridement is a benefit once per tooth per lifetime.
- Pulpotomies and pulpal therapy procedures are limited to primary teeth.
- Benefits for certain oral surgery procedures are subject to Delta Dental receiving an operative report and clinical review and may be reduced by benefits provided under the patient's medical benefits coverage, if applicable.
- Root canal therapy in conjunction with overdentures is not a benefit.
- Re-treatment of root canal therapy or re-treatment of surgical procedures involving the root, by the same Provider, within twenty-four (24) months, is considered part of the original procedure and a separate fee is not allowed.
- Apexification benefits are limited to permanent teeth, once per tooth per lifetime. This procedure is not billable to the patient if performed by the same Dentist within twenty-four (24) months of root canal therapy.
- Endodontic endosseous implants and other specialized implant surgical techniques are not a benefit.
- Tooth transplantation, including re-implantation, is not a benefit.
- Periodontal scaling and root planning benefits are limited to once per quadrant or site in a two (2) year period.
- Periodontal cleanings benefits in excess of four (4) per calendar year are subject to clinical review.

- A separate fee for periodontal maintenance is not billable to the patient within three (3) months of other periodontal therapy provided by the same Dentist.
- Periodontal surgeries, such as gingivectomy, gingival flap, osseous surgery, bone grafts and tissue graft procedures are limited to once per site in a three (3) year period. A gingivectomy performed on the same date of service as a restoration is an eligible expense.
- Separate fees for crown lengthening in the same site are not billable to the patient when charged by the same Dentist within three (3) years.
- Separate fees for post operative visits and dressing changes by the same Dentist performing the surgery are not billable to the patient.

Refer to General Limitations and Exclusions, for additional provisions that may apply.

7. MAJOR SERVICES

Crown build-ups and substructures: benefits when necessary to retain a cast restoration due to extensive loss of tooth structure from caries, fracture or endodontic treatment.

Crowns, cast restorations including onlays and veneers, and repairs to covered procedures: benefits when a tooth is damaged by decay or fractured to the point that it cannot be restored by an amalgam or resin filling.

Implants (endosteal): specified services, including repairs, and related prosthodontics.

Prosthodontics: procedures for construction, modification, or repair of bridges, partial or complete dentures.

Nitrous Oxide: non-intravenous conscious sedation

7.1. Limitations on Major Services

- Replacement of any cast restorations (including veneers, crowns, inlays and onlays) and associated procedures (such as cores and substructures) on the same tooth are not a benefit if the previous placement is less than five (5) years old.
- Veneers are not a Covered Service and will be optioned to a resin restoration.
- Replacement of any crown is not a benefit within five years of the previous placement unless the tooth was extracted and replaced with an implant requiring a new crown.
- Replacement of any bridge, removable partial denture or denture is not a benefit if the previous placement is less than five (5) years old unless the loss of additional teeth requires the construction of a new appliance.
- Services that are beyond the standard of care customarily provided, or not necessary to restore function, are limited to the benefit applicable to a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
- Overdentures are not a covered service.
- A separate fee for a crown build-up or substructure is not billable to the patient when enough tooth structure is present to retain a cast restoration.
- Posts and cores, in addition to a crown, are a benefit only on endodontically treated teeth. In addition to the requirement for endodontic treatment, anterior teeth must have insufficient tooth structure to support a cast restoration. Fees are not billable to the patient when these requirements are not satisfied.
- A separate fee for the recementation or repair to crowns, implants, onlays, post and core or bridges within six (6) months of the original treatment by the same Provider is not billable to the patient. After six (6) months, these services are a benefit once per twelve (12) months.
- Surgical placement of eposteal or transosteal implants is not a benefit.
- Surgical placement of an endosteal implant is a benefit once per tooth per five (5) year period.
- Implant retained or supported crowns and retainers with metallic alloy content less than high noble metals are not benefits and will be considered an Optional Service and an allowance will be made for a full cast crown.

- Implant maintenance procedures are limited to once in a twelve (12) month period.
- The replacement of a semi-precision or precision attachment of an implant/abutment supported prosthesis is considered an Optional Service and is not a benefit.
- A separate fee for the removal of an implant is a benefit once per tooth per lifetime.
- A separate fee is not allowed for a radiologic surgical implant index.
- A posterior fixed bridge and a partial denture are not benefits in the same arch. Benefit is limited to the allowance for a partial denture.
- Temporary restorations, temporary implants and temporary prosthodontics are considered part of the final restoration. A separate fee by the same Provider is not allowed.
- Benefits for porcelain crowns or porcelain supported prosthetics are allowed on any tooth.
- Initial prosthetic placement for congenitally missing teeth is not covered.
- Maxillofacial prosthetics and related services are not a benefit.
- Crowns, implants and prosthodontics and all related services are allowed without age limitations.
- Fees for full or partial dentures include any reline/rebase, adjustment or repair required within six (6) months of delivery except in the case of immediate dentures. After six (6) months, adjustments to dentures are a benefit twice in a twelve (12) month period and relines or rebases are a benefit once in a three (3) year period.
- Tissue conditioning is not a benefit more than twice per denture unit in a three (3) year period.

Refer to General Limitations and Exclusions, for additional provisions that may apply.

8. ORTHODONTIC SERVICES

Orthodontic Services are not a covered benefit under the Value Plan.

Orthodontic Services means procedures performed by a Dentist using appliances to treat poor alignment of teeth and their surrounding structure. The benefit determination for the orthodontic services lifetime maximums may include specific non-orthodontic procedure codes that are directly related, as determined by Delta Dental, to be part of an orthodontic treatment plan.

Procedures directly related to orthodontic services will only be considered eligible expenses if benefits for orthodontic services apply.

Payment for charges that exceed the maximum benefit applicable to orthodontic services is the patient's responsibility.

The orthodontic services have a lifetime maximum benefit DCP participant, based on the plan chosen.

8.1. Limitations on Orthodontic Services

- If the enrolled person is already in orthodontic treatment or any applicable benefit waiting period, benefits shall commence with the first treatment rendered following the patient's effective date. Charges for treatment incurred prior to the patient's effective date are not covered.
- Benefits are determined based on the total cost and total months of treatment.
- Benefits will end immediately if orthodontic treatment is stopped.
- Charges to repair or replace any orthodontic appliance are not covered, even when the appliance was a covered benefit under this or any other plan.
- Charges for radiographic images (except for cephalometric radiographic image) and extractions are not covered under orthodontic services.
- Oral/facial photographic images and diagnostic casts are a benefit once per orthodontic treatment program. Additional fees for these procedures are not billable to the patient when performed by the same Dentist.

Refer to General Limitations and Exclusions, for additional provisions that may.

9. GENERAL LIMITATIONS AND EXCLUSIONS

- Services for any covered procedures that exceed the frequency or age limitation, shown in Benefit Program Coverage, are not eligible for benefits. Unless stated otherwise, all frequency limitations are measured from the last date a procedure was performed according to the patient's dental records.
- Services beyond treatment that is considered the standard of dental care customarily provided, or which are not necessary to restore function, are considered Optional Services. If You receive Optional Services, benefits may be provided based on the customary or standard procedure. A determination of Optional Services is not an opinion or judgment on the quality or durability of the service. You will be responsible for any difference between the cost of Optional Services and any benefit payable.
- Treatment of injuries or illness covered by Workers' Compensation or Employers' Liabilities Laws or services received without cost from any federal, state or local agencies are not a benefit.
- Services for congenital or developmental malformations are not covered. Such malformations include, but are not limited to, cleft palate, upper and lower jaw malformations, and enamel hypoplasia (lack of development). Services provided to newborn children enrolled from birth for congenital defects or birth abnormalities are not, however, excluded from coverage.
- Treatment to restore tooth structure lost from wear unless there is visible decay or fracture on the tooth structure is not covered.
- Cosmetic surgery or procedures are not covered.
- Prosthodontic services or any single procedure started before the patient is covered under the DCP are not eligible for benefits.
- Prescribed drugs, pain medications, desensitizing medications and therapeutic drug injections are not covered.
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the medical Provider for treatment in any such facility are not covered services.
- Extra oral soft tissue grafts (grafting of tissues from outside the mouth to oral tissues) or bone graft accession from a donor site are not a benefit.
- Treatment of the temporomandibular joint disease (TMD) is not a covered expense.
- Treatment must be provided by a licensed Dentist or a person who by law may work under a licensed Dentist's direct supervision.
- A separate charge for office visits, non-diagnostic consultations, case presentations or broken appointments is not covered.
- Treatment to correct harmful habits is not covered.
- A separate charge is not allowed for behavior management, infection control sterilization, supplies, and materials.
- Charges for services or supplies that are not necessary according to accepted standards of dental practice are not benefits.
- Charges for services, supplies, or devices that are not a Dental Necessity are not benefits.

- Procedures considered Experimental or Investigational, as determined by Delta Dental, are not covered.
- A hemisectioned tooth will not be benefited as two (2) separate teeth.
- Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion is not a benefit.
- Treatment to stabilize teeth is not a benefit.
- Replacement of existing restorations (fillings) for any purposes other than treating active tooth decay or fracture is not covered. A tooth fracture or crack is defined as tooth structure that is mobile and/or separated from the natural tooth structure.
- Charges for treatment of craze lines are not a benefit. A craze line is defined as a visible micro-fracture located in coronal enamel that does not break or split the continuity of the tooth structure.
- Separate fees are not allowed for procedures, which are routinely considered by Delta Dental to be part of another service, if performed by the same Dentist on the same date of service.

10. COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies when a person is covered by more than one health plan. Under COB, each plan is determined to be either “primary” or “secondary.”

When the DCP benefits are primary, its benefits apply regardless of benefits applicable under a second plan. When the DCP benefits are secondary (another health plan is primary), COB provisions under the DCP are designed to provide Company participants benefits equal to the benefits that would have applied had the DCP been the only plan, not to exceed the total amount of the actual charges.

COB claims, like all claims under the DCP, are considered on a total claim basis. This means that the determination of what secondary benefits may be payable under the DCP is based on the total amount of all charges shown on a claim as it was submitted and/or paid by the primary plan, even when multiple procedures (such as those done during a single appointment) were performed.

When the DCP is secondary, its payments will be based on the amount remaining after the primary has paid. The DCP will not pay more than that amount, and it will not pay more than it would have paid as primary.

You will provide Delta Dental with the necessary information needed to administer COB. Depending on whether the DCP is primary or secondary, Delta Dental may release required information or need to obtain required information in order to coordinate Your benefits.

Delta Dental has the right to recover the value of any benefits provided under the DCP that exceed its obligations under the terms of this provision from you, a dental Provider, insurance company, or claims administrator to whom excess benefits were paid.

If You receive coverage under Your medical plan for crowns or other prostheses required as a result of implants, You cannot submit any remaining portion to the DCP for Coordination of Benefits. Refer to the Employee H&W Plan Summary Plan Description or the Post-Employment H&W Plan Summary Plan Description for more information on Coordination of Benefits.

Claims questions may be directed to Delta Dental at 800-264-2818. Because of the coordination required, COB claims may require an extended processing time. Please allow Delta Dental at least 30 days before inquiring about the status of Your claim.

11. HOW TO FILE A CLAIM

This section provides an overview of how to file a claim with Delta Dental and the receipt of benefit payments.

11.1. Filing an Initial Claim

Refer to the Claims and Appeals Procedures section in the Employee H&W Plan Summary Plan Description or the Post-Employment H&W Plan Summary Plan Description for information on time frames for initial claims decisions.

IMPORTANT: All claims must be submitted within one year after the date of service in order to be eligible for consideration of payment. The one-year requirement will not apply if You are legally incapacitated.

11.2. In-Network Claims Processing

When You seek services through an in-network Provider, the Provider verifies eligibility and submits the claims directly to Delta Dental for You. There are no claim forms necessary to obtain DCP benefits.

11.3. Out-of-Network Claims Processing

When You seek services through an out-of-network (Non-Participating) Provider, the Non-Participating Dentist may require You to submit their claim form to Delta Dental. Check with Your Dentist to verify whether they will submit Your claim form on Your behalf. It is Your responsibility to verify eligibility for benefits. Call Delta Dental at 800-264-2818 to verify benefit eligibility. You may also verify eligibility and benefits online at the Member Portal www.deltadentalnm.com/snl.

11.3.1. The out-of-network claim process:

- Obtain a claim form from Delta Dental by calling 800-264-2818 or online at www.deltadentalnm.com.
- Complete the claim form including the Patient Section. Prior to submission to Delta Dental, the dental office providing services must complete an itemization of services that includes:
 - Tooth number, if applicable
 - Description of each individual service
 - Date of service
 - Fee for each individual service
 - Signature of the Dentist

For out-of-country claims, Delta Dental requires an itemized receipt indicating the country's currency. Please contact the Delta Dental Customer Service Department at 800-264-2818 for assistance with filing an out-of-country claim. Upon review of any out-of-country claim, Delta Dental may respond to You with a letter requiring Your signature acknowledging You received the specified services.

Delta Dental will calculate foreign currency Benefit payments based on published currency conversion tables that correspond to the date of service.

If the services performed outside of the United States are for extractions, crowns, bridges, dentures, or partial dentures, a radiographic image of the area must be obtained prior to the service being

considered for Benefits. Enrolled Persons are responsible for obtaining the necessary documentation for services provided, filing a claim with Delta Dental, and paying the Provider at the time services are performed.

Completed claim forms should be mailed to:

Delta Dental of New Mexico
100 Sun Avenue NE, Suite 400
Albuquerque, NM 87109

11.3.2. When to submit the claims:

Submit the claim form to Delta Dental, the claims administrator, immediately after the dental care expense is incurred or prior to one year from the date of service.

Note: Completion and submission of the claim form does not guarantee eligibility of benefits.

11.4. Benefit Payments

Refer to the Employee H&W Summary Plan Description or the Post-Employment H&W Summary Plan Description for general information on benefits payments.

11.4.1. Stale-Dated Checks and Uncashed Benefit Payments

Delta Dental considers a check as stale-dated after 120 days. To give you time to respond, a stale-date letter is automatically generated and mailed at 90 days to the address on file. This letter outlines four response options: (1) you never received the check and would like it reissued, (2) you lost or misplaced the check and would like it reissued, (3) you received and cashed the check, or (4) other, where you can provide additional details or special requests.

The letter includes contact information (phone, fax, email, and mailing address) so you can return your response or reach customer service. Once your response is received, DDNM will either discard the request if no action is needed or reissue the check as requested. If no response is received, the check will remain outstanding until it is potentially escheated to the state. If that occurs, DDNM will complete a due diligence process and attempt to contact you again, following a similar notification procedure.

11.5. Network (Participating) Provider Benefits

You will pay the applicable Deductible and Coinsurance amount for basic and restorative, major, or orthodontic dental care services to the network (Participating) Provider at the time services are rendered.

11.6. Non-Network (Non-Participating) Provider

You are responsible for filing claims for services received from a Non-Participating Dentist.

Within 30 days of receiving a valid claim, Delta Dental will send an Explanation of Benefits, which records Delta Dental's benefit determination on behalf of the DCP, any payment made by Delta Dental on behalf of the DCP, and any amount still owed to the dental Provider. The Explanation of Benefits will be mailed to the primary covered Subscriber, or other appropriate beneficiary, and to the treating Dentist if a Delta Dental Participating Dentist. The 30-day period for claim determination may be extended an additional 15 days if matters beyond the control of Delta Dental

delay benefit determination. Notification of any necessary extension will be sent prior to the expiration of the initial 30-day period.

If a claim for benefits is reduced or denied, the Explanation of Benefits will state the reason for the Adverse Determination. If You believe Delta Dental incorrectly denied all or part of a claim, a review may be requested by following the claim appeals process.

If You have not been notified about a claim within 60 days of filing a claim, contact Delta Dental, the Claims Administrator, at 800-264-2818.

You may appoint an Authorized Representative to make contact with Delta Dental on Your behalf with respect to any benefit claim You file or any review of a denied claim You wish to pursue. To request a form to designate the person You wish to appoint as Your representative, You should go online to www.deltadentalnm.com or contact Delta Dental's Customer Service Department toll free 800-264-2818 or write them at:

Delta Dental of New Mexico
100 Sun Avenue NE, Suite 400
Albuquerque, NM 87109

Once You have appointed an authorized representative, Delta Dental will communicate directly with Your representative.

11.7. To Whom Benefits Are Paid

On behalf of the DCP, Delta Dental will:

- Pay a Participating Provider directly for covered services rendered. You are responsible for paying the Provider directly for any Coinsurance, Deductible and any non-covered services.
- Pay a New Mexico Non-Participating Provider when a valid assignment of benefits is received on the individual claim.
- Pay a Non-Participating Provider practicing outside the state of New Mexico when required by the Delta Dental Plan in that state, when a valid assignment of benefits is received on the individual claim.
- Pay directly to the Human Services Department or Indian Health Services any eligible dental benefits under the DCP that have already been paid or are being paid by the Human Services Department or Indian Health Services on Your behalf under the State's Medicaid Program or Indian Health Program.
- Send benefit payments directly to Participating Providers in cases of a Qualified Medical Child Support Order (QMCSO). Payment of benefits for services obtained from Non-Participating Providers will be directed in compliance with the valid order of judgment provided in the QMCSO.
- The Claims Administrator furnishes claim forms to the Company. Claims forms can be obtained from the Delta Dental Member Portal at www.deltadentalnm.com or by calling Delta Dental Customer Service, toll free, at 800-264-2818.

Note: If You used a Delta Dental network provider, the Dentist will file the claim on Your behalf.

11.8. Right to Recover Excess Payments

The Claims Administrator has the right, at any time, to recover any amount paid by the DCP for covered charges in excess of the amount that should have been paid under the DCP provisions. Payments may be recovered from You, Providers of service, and other group health plans. The right to recover a payment includes the right to deduct the amount paid from future dental benefits for any covered family member.

IMPORTANT: By accepting benefits under the DCP, You agree to reimburse payments made in error and cooperate in the recovery of excess payments.

12. HOW TO FILE AN APPEAL

You may request a review or an appeal of an adverse Pre-Treatment Estimate or Adverse Determination on a claim by following the claim appeal process and procedures. An Adverse Determination means a denial, reduction or termination of a benefit or a failure to make payment, in whole or in part, on a claim. This section outlines how to file an appeal with Delta Dental.

Note: Upon denial of a claim, You have 180 calendar days of receipt of the notification of Adverse Determination to appeal the claim. You must exhaust the appeals process before You can seek legal recourse.

If a claim for benefits is denied in part or in whole, You have the right to appeal the claim. A request for further information from the Provider is not a claim denial.

Note: Regardless of the decision and/or recommendation of Delta Dental, the Company, or what the Program will pay, it is always up to You and the doctor to decide what, if any, care You receive.

Most claims-related requests may be handled informally by calling Delta Dental Customer Service, toll free, at 800-264-2818. You always have the opportunity to describe problems, submit explanatory information and allow Delta Dental to correct any errors quickly.

12.1. Formal Claim Appeal Process

The table below outlines who to contact based on the reason for the claim denial:

If you have a claim denied because of...	Then...
Eligibility (except for incapacitation determinations)	See the “Eligibility Appeals Procedure” in the Claims and Appeals Procedures section in the Employee H&W Plan Summary Plan Description or the Post-Employment H&W Plan Summary Plan Description.
Eligibility Based on Incapacitation	Contact HR Solutions at 505-284-4700.
Benefit Determination	Refer to the procedure noted below.

Before requesting a formal appeal, You may informally contact Delta Dental Customer Service at 800-264-2818. If the customer service representative cannot resolve the issue to Your satisfaction over the phone, You may submit Your question in writing at the address noted below. If You are not satisfied with a claims determination, You may appeal it as described below, without first informally contacting Delta Dental Customer Service.

If You disagree with a Pre-Treatment Estimate or post-service claim determination, You can contact Delta Dental in writing to request a formal appeal. If You are appealing an Adverse Determination of a treatment plan that includes more than one date of service, You will have to do so as soon as possible so that You may receive a decision on review before the course of treatment is completed.

To request a formal appeal of Your claim, You must send Your request in writing to:

**Claims Administrator
Delta Dental of New Mexico
100 Sun Avenue NE, Suite 400
Albuquerque, NM 87109**

You must include Your name and address, the Subscriber's Member ID number, the reason You believe Your claim was wrongly denied, and any other information You believe supports Your claim, and indicate in Your letter that You are requesting a formal appeal of Your claim. You also have the right to review the DCP and any documents related to it. If You would like a record of Your request and proof that it was received by Delta Dental, You should mail it certified mail, return receipt requested.

The decision as to whether to request a review or to appeal a claim will not affect Your right to any other benefits under the Program. In addition, the following provisions are assured. You:

- Will be notified in writing by Delta Dental of any Adverse Determination and the reason(s) for the Adverse Determination;
- May submit written comments, documents, records, narratives, radiographs, clinical documentation and other information relating to the claim, which Delta Dental will take into consideration, whether or not such information was submitted or considered in the initial benefit determination;
- May choose a representative to act on Your behalf at Your expense;
- Will not be charged any fees or costs incurred by Delta Dental as part of the appeals process;
- Will receive a response to the appeal from Delta Dental in writing within 30 days of receipt of the request;
- Can be assured that the review of any Adverse Determination under appeal will not be conducted by the same person or a subordinate of the person who determined the initial Adverse Determination.
- The Dental Consultant or any other person(s) reviewing Your claim will not be the same as, nor will they be subordinate to, the person(s) who initially decided Your claim. The Dental Consultant will grant no deference to the prior decision about Your claim. Instead, he or she will assess the information, including any additional information that You have provided, as if he or she were deciding the claim for the first time.

The Dental Consultant will make a decision within 30 days of receiving Your request for the review of Pre-Treatment Estimate or Post-Service Claims. You will be notified in writing if Your claim is denied upon review (in whole or in part).

If You are not satisfied with the results of the review (first level appeal decision), You have the right to request a second level appeal. Your second level appeal request must be submitted in writing within 60 days from receipt of the first level appeal decision. A second level appeal includes all procedures applicable during first level appeals, but the review will be conducted by a Dental Consultant or other person who was not involved in the initial determination or the first level appeal process. The second level appeal decision will be made within 30 days of receiving the request for a second level appeal.

If the results of the second level review determine that benefits are applicable, Delta Dental will recalculate the claim for available benefits and send written notification of payment to You. In the

event the first level appeal decision is supported by the second level review process, the Adverse Determination will be upheld and You will again be notified in writing.

Delta Dental will notify You of the decision regarding any appeal within the applicable time periods. For those time periods and more information on the appeals process, refer to the Claims and Appeals Procedure section of the Employee H&W Plan Summary Plan Description or the Post-Employment H&W Plan Summary Plan Description.

13. ADMINISTRATIVE SERVICES

13.1. Claims Administrator

The Claims Administrator is the third-party administrator designated by the Company to receive, process, and pay claims according to the provisions of the DCP. The Claims Administrator for the DCP is Delta Dental.

13.2. Member Services

Member services are provided through Delta Dental of New Mexico. You can call Delta Dental Customer Service at 800-264-2818, 24 hours a day, seven days a week for information on eligibility; benefit levels; claim status; time limitations; benefits on oral exams, cleanings, and radiographic images; Delta Dental's mailing address; and names of Participating Dentists near You.

If You have additional questions and need to speak with a Customer Service associate, call Delta Dental of New Mexico Customer Service to speak with an associate Monday through Friday. The times the Delta Dental of New Mexico associates are available are:

- From 6:00 a.m. to 6:00 p.m. MT
- From 5:00 a.m. to 5:00 p.m. PT

13.3. Member ID Card

Delta Dental provides member identification (ID) cards to new members. The ID card shows the name of the primary covered Subscriber and the group number. All family members' eligibility will be filed under the primary covered Subscriber.

If You require additional ID cards You may call Delta Dental at 800-264-2818 or visit the Member Portal at www.deltadentalnm.com/snl to print an ID card.

13.4. Claims Administrator Website

Create an account with Delta Dental's Member Portal for consumer information at www.deltadentalnm.com/snl It provides all the information You need to learn more about the DCP, review claims and claim payments, access searchable Dentist directories, or print an ID card.

13.5. Delta Dental Addresses

Mail claims and written inquiries to:

**Delta Dental of New Mexico
100 Sun Avenue NE, Suite 400
Albuquerque, NM 87109**

14. DEFINITIONS

Term	Definition
Adverse Determination	<p>When a licensed Dentist and/or appropriate dental service Provider has performed a review and denied authorization for the requested service(s) based on guidelines, denial of dental care benefits usually occurs for one of the following reasons:</p> <p>You are ineligible for requested services;</p> <p>The requested service does not meet approved clinical criteria; and/or;</p> <p>Benefit limitations/maximums have been met.</p>
Benefit Period	<p>The time period for accumulating the Deductible, the benefit maximum and the time during which frequency limitations apply, as shown in this Benefit Summary.</p>
Coinsurance	<p>The percentage of the network dental Provider's Maximum Approved Fee that You are required to pay. The out-of-network Provider will balance bill patients for any amount above the Delta Dental Maximum Approved Fee.</p>
Covered Member	<p>An enrolled participant or enrolled Dependent. This term refers to a person only while enrolled under the DCP. References to "You" and "Your" throughout this document are references to a Covered Member.</p>
Deductible	<p>The amount You or Your family must pay toward covered services before Delta Dental makes any payment on behalf of the DCP for those covered services.</p>
Delta Dental of New Mexico	<p>The claims administrator selected by the Company to administer the DCP.</p>
Dental Consultant	<p>An independent contractor paid by Delta Dental of New Mexico to conduct claims review. The review of dental insurance claims is defined in the practice of dentistry in the New Mexico Dental Practice Act. A Dental Consultant must be a licensed Dentist as well as actively practicing dentistry. A Dental Consultant has no affiliation or connection with Delta Dental other than as an independent consultant or a Delta Dental Participating Dentist.</p>
Dental Necessity	<p>A service or supply provided by a Dentist or other Provider that has been determined by Delta Dental as generally accepted dental practice for Your diagnosis and treatment. Delta Dental may use Dental Consultants to determine generally accepted dental practice standards and if a service is a Dental Necessity. These services or supplies are in accordance with generally accepted local and national standards of dental practice, and not primarily for Your convenience or that of the Provider. The services/supplies are the most appropriate that can safely be provided. The fact that a Provider has performed or prescribed a service or supply does not mean it is a Dental Necessity.</p>
Dentist	<p>A duly licensed Dentist legally entitled to practice dentistry.</p>
Experimental/Investigational	<p>A treatment, procedure, facility, equipment, drug, device or supply that is not accepted as standard dental treatment for the conditions being treated or any items requiring Federal or other governmental agency approval if</p>

Term	Definition
	<p>such approval had not been granted at the time services were rendered. To be considered standard dental practice and not Experimental/Investigational, the treatment must have met all of the following criteria:</p> <p>A technology must have final approval from the appropriate regulatory governmental bodies;</p> <p>The scientific evidence as published in peer-review literature must permit conclusions concerning the effect of the technology on health outcomes;</p> <p>The technology must improve the net health outcome;</p> <p>The technology must be as beneficial as any established alternatives; and</p> <p>The technology must be attainable outside the Investigational settings.</p>
Maximum Approved Fee	The maximum DCP allowance, as determined by Delta Dental, considered for each dental procedure before application of Coinsurance and/or Deductible.
Non-Participating Dentist	A Dentist who has not signed a contract with any Delta Dental Plan to participate in any of Delta Dental's provider networks. Non-Participating Dentists do not accept Delta Dental's Maximum Approved Fees. Non-Participating Dentists may bill the patient the full submitted amount.
Optional Services	Services beyond treatment that is considered the standard of care customarily provided, or which are not necessary to restore function, are considered "Optional Services."
Participating Dentist	A Dentist who has agreed to abide by a Delta Dental Participating Dentist Agreement.
Pre-Treatment Estimate	An advance estimate of benefits payable under the DCP as requested by the dental Provider prior to performing a recommended treatment for You. A predetermination of benefits is subject to all maximums, Deductibles, eligibility and all other DCP provisions at the time services are actually performed. A Predetermination of Benefits is not required as a condition for payment of benefits.
Provider	A legally licensed Dentist, or any other legally licensed dental practitioner, rendering services within the scope of that practitioner's license.
Subscriber	The primary DCP participant, such as an Employee, who is not enrolled as a Dependent.

APPENDIX A

Dental Plan Summary				Plans in 2026 For Active Employees					
	Value Plan			Standard Plan***			Plus Plan **		
Single Deductible	\$50			\$50			\$50		
Family Deductible	\$150			\$150			\$150		
Maximum Annual Benefit	\$1,000			\$1,800			\$3,000		
Preventive Care Security Included *	Yes			Yes			Yes		
Fluoride treatment for adults is covered as preventive if medically necessary once per Calendar Year	Yes			Yes			Yes		
Nitrous oxide covered as a Major Service	Yes			Yes			Yes		
Lifetime Child/Adult Ortho Maximum	No benefit			\$1,800			\$3,000		
Deductible applies to orthodontia	NA			No deductible applies to ortho			No deductible applies to ortho		
Benefit Payment % By Provider Type	<u>Delta</u>	<u>Delta</u>	<u>Non-</u>	<u>Delta</u>	<u>Delta</u>	<u>Non-</u>	<u>Delta</u>	<u>Delta</u>	<u>Non-</u>
	<u>Dental</u>	<u>Dental</u>	<u>Participating</u>	<u>Dental</u>	<u>Dental</u>	<u>Participating</u>	<u>Dental</u>	<u>Dental</u>	<u>Participating</u>
	<u>PPO</u>	<u>Premier</u>		<u>PPO</u>	<u>Premier</u>		<u>PPO</u>	<u>Premier</u>	
Diagnostic and Preventive Services	100%	100%	50%	100%	100%	50%	100%	100%	50%
Basic & Restorative Services	70%	60%	40%	80%	70%	50%	90%	80%	50%
Major Services	35%	25%	25%	55%	45%	45%	65%	55%	50%
Orthodontic Services	No Coverage			50%	50%	50%	60%	60%	50%
<p>* Preventive Care Security (PCS): In-network diagnostic and preventive don't count toward maximum annual benefit. PCS is not available when utilizing a non-participating provider.</p> <p>** Individuals choosing the Plus Plan must remain enrolled in the plan for at least two consecutive plan years.</p> <p>***Plan offered to Sandia Retirees.</p>									