

DELTA DENTAL PPO PLUS PREMIER - COMPREHENSIVE ENHANCED

Dental Benefit Plan Summary

Grand Forks Public Schools
Group Number 433364

RIGHT TO CANCEL: You may cancel this coverage by delivering or mailing a written notice or sending a telegram to Delta Dental of Minnesota, P.O. Box 330, Minneapolis, MN 55440-0330 and by returning this booklet to us before midnight of the tenth day after the date you receive it. Notice given by mail and return of the policy or contract by mail are effective on being postmarked, properly addressed and postage prepaid.

Delta shall, within ten days after it receives notice of cancellation, return the difference between any premiums paid by the Group Subscriber and any benefits paid by Delta on your behalf.

DENTAL BENEFIT PLAN SUMMARY

This is a Summary of your Group Dental Program
(**PROGRAM**) prepared for Covered Persons with:

Grand Forks Public Schools
(**GROUP**)

This Program has been established and is maintained and administered in accordance with the provisions of your Group Dental Plan Contract Number **433364** issued by DELTA DENTAL OF MINNESOTA (**PLAN**).

IMPORTANT

This booklet is subject to the provisions of the Group Dental Agreement and cannot modify this agreement in any way; nor shall you accrue any rights because of any statement in or omission from this booklet.

DELTA DENTAL OF MINNESOTA
National Dedicated Service Center
P.O. Box 59238
Minneapolis, Minnesota 55459
(651) 406-5901 or (800) 448-3815
www.deltadentalmn.org

**DELTA DENTAL OF MINNESOTA
NOTICE OF INFORMATION PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Delta Dental of Minnesota is required by law to maintain the privacy of your Protected Health Information, to provide you with this notice of its legal duties and privacy practices with respect to your Protected Health Information and to notify you following a breach of unsecured Protected Health Information. This notice is being issued to comply with the requirements of the Privacy Rules under the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rules"). Individually identifiable information about your past, present or future health or condition, the provision of health care to you, or payment for such health care is considered "Protected Health Information" ("PHI"). Health care includes dental care.

Our Permitted Uses and Disclosures of Your Protected Health Information

We use and disclose PHI about you without your authorization for treatment, payment, and health care operations.

Treatment: We may disclose PHI to your dentist(s) for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seek information from us as to whether the service has been previously provided.

Payment: We use and disclose your PHI in order to fulfill our duty to provide your coverage, determine your benefits, and make payment for services provided to you. For example, we may use and disclose your PHI in order to process your claims.

Health Care Operations: We use and disclose your PHI as a part of certain operations, such as quality improvement. For example, we may use and disclose your PHI to evaluate the quality of dental services that were performed or to check for fraud and abuse.

We may not, however, use or disclose any PHI that is considered genetic information under Federal Law for underwriting purposes.

We may be asked by the sponsor of your dental benefits to provide your PHI to the sponsor. We will do so if permitted by law.

Unless you object, we may disclose your PHI to a family member, other relative, person authorized by law, or any other person you identify as involved in your care or the payment related to your care. Only PHI relevant to that person's involvement in your care or the payment related to your care will be disclosed. You can restrict this disclosure at any time, subject to certain limitations. If you are incapacitated or in the event of an emergency, we will exercise professional judgment to determine whether a disclosure of this type is in your best interest.

We may also use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may use or disclose your PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We may disclose PHI in response to a court or administrative order, subpoena, discovery request or other lawful process if certain conditions are met and the required assurances are received. We provide PHI when otherwise required by law, such as for law enforcement purposes. We may disclose your PHI to public health or other appropriate authorities to lessen a serious or imminent threat to the health or safety of you or the public. In any other situations not described here, we will ask for your written authorization before using or disclosing your PHI. If you choose to sign an authorization to allow disclosure of your PHI, you can later revoke that authorization to stop any future uses and disclosures (other than for treatment, payment and health care operations).

We reserve the right to change this notice at any time and for any reason. We reserve the right to make the revised or changed notice effective for PHI we currently maintain as well as any information received in the future. A copy of our most current notice will be posted at www.deltadentalmn.org.

Individual Rights

In most cases, you have the right to view or get a copy of your PHI which is held in a particular record set by us. You may request copies for a nominal per-page charge. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your PHI for treatment, payment and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations, if you clearly state that disclosure of all or part of your PHI could endanger you. You also have the right to receive notice following an unauthorized access, use or disclosure of your PHI if that unauthorized access, use or disclosure is considered a "breach" as defined by the HIPAA Privacy Rules.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, request a paper copy of this Notice or if you have any questions, complaints or concerns, please contact:

National Dedicated Service Center
P.O. Box 59238
Minneapolis, Minnesota 55459
(651) 406-5901 or (800) 448-3815

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SUMMARY OF DENTAL BENEFITS

After you have satisfied the deductible, if any, your dental program pays the following percentages of the treatment cost, up to a maximum fee per procedure. The maximum fee allowed by Delta is different for Delta Dental PPO dentists, Delta Dental Premier dentists and nonparticipating dentists. If you see a nonparticipating dentist, your out-of-pocket expenses may increase.

	<u>Delta Dental PPO</u>	<u>Delta Dental Premier</u>	<u>Out-of- Network</u>
Diagnostic and Preventive Services	100%	100%	100%
Basic Services	80%	80%	80%
Endodontics	50%	50%	50%
Periodontics	50%	50%	50%
Oral Surgery	50%	50%	50%
Major Restorative Services*	50%	50%	50%
Prosthetic Repairs and Adjustments	50%	50%	50%
Prosthetics	50%	50%	50%

*Procedures under the same category of services may be covered at a different percentage. See Description of Covered Procedures section for details.

Benefit Maximums

The Program pays up to a maximum of \$1,250.00 for each Covered Person per Coverage Year subject to the coverage percentages identified above. Benefit Maximums may not be carried over to future coverage years.

Deductible

There is a \$50.00 deductible per Covered Person each Coverage Year not to exceed three (3) times that amount (\$150.00) per Family Unit.

The deductible does not apply to Diagnostic and Preventive services.

Coverage Year

A Coverage Year is a 12-month period in which deductibles and benefit maximums apply. Your Coverage Year is September 1 through August 31.

DESCRIPTION OF COVERED PROCEDURES

Pretreatment Estimate

(Estimate of Benefits)

IT IS A GOOD IDEA TO GET A PRETREATMENT ESTIMATE FOR YOUR DENTAL CARE THAT INVOLVES MAJOR RESTORATIVE, PERIODONTIC, OR PROSTHODONTICS. THE PRETREATMENT ESTIMATE IS RECOMMENDED, BUT NOT REQUIRED FOR YOU TO RECEIVE BENEFITS FOR COVERED DENTAL CARE. THE PRETREATMENT ESTIMATE IS A VALUABLE TOOL FOR BOTH THE DENTIST AND YOU. SUBMISSION OF A PRETREATMENT ESTIMATE ALLOWS THE DENTIST AND YOU TO KNOW WHAT BENEFITS YOU HAVE AND IF THE TREATMENT IS COVERED. THE PRETREATMENT ESTIMATE WILL OUTLINES WHAT YOU HAVE TO PAY TO THE DENTIST SUCH AS CO-PAYMENTS AND DEDUCTIBLES. IT ALLOWS THE DENTIST AND YOU TO MAKE ANY NECESSARY FINANCIAL ARRANGEMENTS BEFORE TREATMENT BEGINS. THIS PROCESS DOES NOT PRIOR AUTHORIZE THE TREATMENT NOR DETERMINE ITS DENTAL OR MEDICAL NECESSITY. THE ESTIMATED PAYMENT IS BASED ON YOUR CURRENT ELIGIBILITY AND CONTRACT BENEFITS IN EFFECT AT THE TIME OF THE ESTIMATE. THIS IS AN ESTIMATE ONLY. FINAL PAYMENT WILL BE BASED ON THE CLAIM THAT IS SUBMITTED ONCE THE TREATMENT IS COMPLETED. SUBMISSION OF OTHER CLAIMS, A CHANGE IN ELIGIBILITY, A CHANGE IN YOUR CONTRACT COVERAGE OR OTHER COVERAGE MAY ALTER THE PAYMENT.

After the exam, your dentist will tell you the dental treatment that should be given. If the dental treatment involves major restorative, periodontics, or prosthetics, the dentist should submit a claim form to the Plan for the proposed treatment. The Plan will review and determine if the treatment is covered and estimate the amount of payment.

A Pretreatment Estimate of Benefits statement will be sent to you and your dentist. You will be responsible to pay any deductibles and coinsurance amounts. You will also be responsible to pay for any dental treatment that is not considered a covered service under the Plan.

Benefits

The Program covers the following dental procedures when they are performed by a licensed dentist and when necessary and customary as determined by the standards of generally accepted dental practice. The benefits under this Program shall be provided whether the dental procedures are performed by a duly licensed physician or a duly licensed dentist, if otherwise covered under this Program, provided that such dental procedures can be lawfully performed within the scope of a duly licensed dentist.

As a condition precedent to the approval of claim payments, the Plan shall be entitled to request and receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which a dentist's care is provided, such information and records relating to a Covered Person as may be required to pay claims. Also, the Plan may require that a Covered Person be examined by a dental consultant retained by the Plan in or near the Covered Person's place of residence. The Plan shall hold such information and records confidential.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN YOUR DELTA DENTAL PREMIER AND DELTA DENTAL PPO NETWORKS PRIOR TO RECEIVING DENTAL CARE.

Delta Dental of Minnesota does not determine whether a service submitted for payment or benefit under this Plan is a dental procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. Delta Dental evaluates dental procedures submitted to determine if the procedure is a covered benefit under your dental plan. Your dental Plan includes a preset schedule of dental services that are eligible for benefit by the Plan. Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this plan. While these services may be necessary for your dental condition,

they may not be covered by us. There may be an alternative dental care service available to you that is covered under your plan. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any coinsurance or deductible you may have. Services that are not covered by the Plan or exceed the frequency of Plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for dental services that are not covered or benefited by the Plan. The decision as to what dental care treatment is best for you is solely between you and your dentist.

ONLY those services listed are covered. Deductibles and maximums are listed under the Summary of Dental Benefits. Services covered are subject to the limitations within the Benefits, Exclusions and Limitations sections described below. For estimates of covered services, please see the "Pretreatment Estimate" section of this booklet.

PREVENTIVE CARE (Diagnostic & Preventive Services)

Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per contract year.

NOTE: Comprehensive oral evaluations will be benefited 1 time per dental office, subject to the 2 times per contract year. Any additional comprehensive oral evaluations performed by the same dental office will be benefited as a periodic oral evaluation and will be subject to the 2 times per contract year.

Radiographs (X-rays)

- **Bitewings** - Covered at 1 series of films per 12 month period.
- **Full Mouth (Complete Series) or Panoramic** - Covered 1 time per 60-month period.
- **Periapical(s)** - 4 single X-rays are covered per 12-month period.
- **Occlusal** - Covered at 1 series per 12-month period.

Dental Cleaning

- **Prophylaxis** - Covered 2 times per contract year.

Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

NOTE: A prophylaxis performed on a Covered Person under the age of 14 will be benefited as a child prophylaxis. A prophylaxis performed on a Covered Person age 14 or older will be benefited as an adult prophylaxis.

- **Periodontal Maintenance** - Covered 2 times per contract year.

Periodontal Maintenance is a procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Fluoride Treatment (Topical application of fluoride) - Covered 1 time per 12-month period for dependent children through the age of 14.

Oral Hygiene Instructions - Instructions which include tooth-brushing techniques, flossing and use of oral hygiene aids are covered 1 time per lifetime.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered 1 time per lifetime for permanent first and second molars of eligible dependent children through the age of 14.

Space Maintainers - Covered 1 time per lifetime on eligible dependent children through the age of 14 for extracted primary posterior (back) teeth.

LIMITATION: Repair or replacement of lost/broken appliances is not a covered benefit.

EXCLUSIONS - Coverage is NOT provided for:

1. Restorations placed for preventive or cosmetic purposes.

BASIC SERVICES

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

- **Anterior (front) Teeth** - Treatment to restore decayed or fractured permanent or primary anterior teeth.
- **Posterior (back) Teeth** - Treatment to restore decayed or fractured permanent or primary posterior teeth.

Benefits shall be limited to the same surfaces and allowances for amalgam (silver filling). The patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

LIMITATION: Coverage for amalgam or composite restorations will be limited to only 1 service per tooth surface per 24-month period.

Basic Extractions

- Removal of Coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Other Basic Services

- **Restorative cast post and core build-up, including pins and posts** - See benefit coverage description under Complex or Major Restorative Services.
- **Pre-fabricated or Stainless Steel Crown** - Covered 1 time per 24-month period for eligible dependent children through the age of 18.

Adjunctive General Services

- **Intravenous Conscious Sedation and IV Sedation** - Covered when performed in conjunction with complex surgical service.

LIMITATION: Intravenous conscious sedation and IV sedation will not be covered when performed with non-surgical dental care.

EXCLUSIONS - Coverage is NOT provided for:

1. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care.
2. Case presentation and office visits.
3. Athletic mouthguard, enamel microabrasion, and odontoplasty.
4. Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes, but is not limited to whitening agents, tooth bonding and veneers.
5. Placement or removal of sedative filling, base or liner used under a restoration.
6. Pulp vitality tests.
7. Diagnostic casts.
8. Adjunctive diagnostic tests.
9. Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

BASIC ENDODONTIC SERVICES (NERVE OR PULP TREATMENT)

Endodontic Therapy on Primary Teeth

- **Pulpal Therapy**
- **Therapeutic Pulpotomy**

Endodontic Therapy on Permanent Teeth

- **Root Canal Therapy**
- **Apicoectomy**
- **Root Amputation on posterior (back) teeth**

Complex or other Endodontic Services

- **Apexification** - For dependent children through the age of 16.
- **Retrograde filling**
- **Hemisection, includes root removal**

LIMITATION: All of the above procedures are covered 1 time per tooth per lifetime.

EXCLUSIONS - Coverage is NOT provided for:

1. Retreatment of endodontic services that have been previously benefited under the Plan.
2. Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).

3. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
4. Intentional reimplantation.
5. Pulp vitality tests.
6. Incomplete root canals.

PERIODONTICS (GUM & BONE TREATMENT)

Basic Non Surgical Periodontal Care - Treatment for diseases for the gingival (gums) and bone supporting the teeth.

- **Periodontal scaling & root planing** - Covered 1 time per 36 months.
- **Full mouth debridement** - Covered 1 time per lifetime.

Complex Surgical Periodontal Care - Surgical treatment for diseases for the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this plan.

- **Gingivectomy/gingivoplasty**
- **Gingival flap**
- **Apically positioned flap**
- **Osseous surgery**
- **Bone replacement graft**
- **Pedicle soft tissue graft**
- **Free soft tissue graft**
- **Subepithelial connective tissue graft**
- **Soft tissue allograft**
- **Combined connective tissue and double pedicle graft**
- **Distal/proximal wedge**

LIMITATION: Only 1 complex surgical periodontal service is a benefit covered 1 time per 36-month period per single tooth or multiple teeth in the same quadrant.

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Bacteriologic tests for determination of periodontal disease or pathologic agents.
3. The controlled release of therapeutic agents or biologic materials used to aid in soft tissue and osseous tissue regeneration.
4. Provisional splinting, temporary procedures or interim stabilization of teeth.
5. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide or therapeutic drug injections, drugs, or medicaments for non-surgical and surgical periodontal care, regardless of the method of administration.

ORAL SURGERY (TOOTH, TISSUE, OR BONE REMOVAL)

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Other Complex Surgical Procedures

- Oroantral fistula closure
- Tooth reimplantation - accidentally evulsed or displaced tooth
- Surgical exposure of impacted or unerupted tooth to aid eruption
- Biopsy of oral tissue
- Transseptal fiberotomy
- Alveoloplasty
- Vestibuloplasty
- Excision of lesion or tumor
- Removal of nonodontogenic or odontogenic cyst or tumor
- Removal of exostosis
- Partial ostectomy
- Incision & drainage of abscess
- Frenulectomy (frenectomy or frenotomy)

Temporomandibular Joint Disorder (TMJ) as covered under Minnesota Statutes Section 62A.043 Subd. 3 -

Dental treatment that is considered surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder, including splints, is subject to the coordination of benefits. A Pre-treatment Estimate of Benefits is recommended.

NOTE: If you or your dependents currently have medical insurance coverage, the claim must first be submitted to that medical insurance program. Any remaining costs after consideration under your medical insurance may be submitted to the Plan for further benefit (see Coordination of Benefits). You must submit a copy of the medical Explanation of Benefits (EOB) along with your claim to this Plan.

If you or your dependents are not eligible for TMJ benefits under another insurance program, either medical or dental, dental services for TMJ will be covered under this dental Plan within the noted Plan limitations, maximums, deductibles and payment percentages of treatment costs.

LIMITATIONS

1. Reconstructive Surgery benefits shall be provided for reconstructive surgery when such dental procedures are incidental to or follows surgery resulting from injury, illness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, to the extent as required by Minnesota Statute 62A.25 provided, however, that such procedures are dental reconstructive surgical procedures.
2. Inpatient or outpatient dental expenses arising from dental treatment up to age 18, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate as required by Minnesota Statute section 62A.042.

For programs without orthodontic coverage: Dental orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit plan.

For programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this plan shall be primary and the other policy or contract shall be secondary.

EXCLUSIONS - Coverage is NOT provided for:

1. Intravenous conscious sedation and IV sedation when performed with non-surgical dental care.
2. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration.
3. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
4. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
5. Surgical exposure of impacted or unerupted tooth for orthodontic reasons.
6. Surgical repositioning of teeth.
7. Inpatient or outpatient hospital expenses.
8. Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.

COMPLEX OR MAJOR RESTORATIVE SERVICES

Services performed to restore lost tooth structure as a result of decay or fracture

Gold foil restorations - Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances. The patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

Inlays - Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION: If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

Onlays and/or Permanent Crowns - Covered 1 time per 5-year period per tooth.

Implant Crowns - See Prosthetic Services.

Crown Repair - Covered 1 time per 12-month period per tooth.

Occlusal Adjustments - Covered 1 time per 36-month period.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface - Covered 1 time per 5-year period when done in conjunction with covered services.

***Recement Inlay, Onlay or Crown** - This service is covered at 80% when service is performed by a Delta Dental PPO, a Delta Dental Premier dentist or a Non-Participating dentist.

Canal prep & fitting of preformed dowel & post

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
3. Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
4. Placement or removal of sedative filling, base or liner used under a restoration.
5. Temporary, provisional or interim crown.
6. Occlusal procedures including occlusal guard.
7. Inlays, onlays or crowns placed for preventive or cosmetic purposes.
8. Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

PROSTHETIC SERVICES (DENTURES, PARTIALS, AND BRIDGES)

Reline and Rebase – Covered 1 time per 36-month period when:

- the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) - Covered when:

- the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Adjustments - Covered 2 times per 12-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Removable Prosthetic Services (Dentures and Partial) - Covered 1 time per 5-year period:

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) - Covered 1 time per 5-year period:

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last 5 years;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Single Tooth Implant Body, Abutment and Crown - Covered 1 time per 5-year period for covered persons age 16 and over. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a Pretreatment Estimate be requested to estimate the amount of payment prior to beginning treatment.

EXCLUSIONS - Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
3. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
4. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
5. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
6. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
7. Services or supplies that have the primary purpose of improving the appearance of your teeth.
8. Placement or removal of sedative filling, base or liner used under a restoration.
9. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
10. Coverage shall be limited to the least expensive professionally acceptable treatment.

Exclusions

Coverage is NOT provided for:

- a) Dental services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving Medical Assistance pursuant to Minnesota Statute Section 62A.045.
- b) Dental services or health care services not specifically covered under the Group Dental Plan Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).
- c) New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.

- d) Dental services performed for cosmetic purposes. NOTE: Dental services are subject to post-payment review of dental records. If services are found to be cosmetic, we reserve the right to collect any payment and the member is responsible for the full charge.
- e) Dental services completed prior to the date the Covered Person became eligible for coverage.
- f) Services of anesthesiologists.
- g) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.
- h) Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.
- i) Dental services performed other than by a licensed dentist, licensed physician, his or her employees.
- j) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- k) Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
- l) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- m) Orthodontic treatment services, unless specified in this Dental Benefit Plan Summary as a covered dental service benefit.
- n) Case presentations, office visits and consultations.
- o) Incomplete, interim or temporary services.
- p) Athletic mouth guards, enamel microabrasion and odontoplasty.
- q) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.
- r) Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
- s) Bacteriologic tests.
- t) Cytology sample collection.
- u) Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.
- v) Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
- w) Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).
- x) The replacement of an existing partial denture with a bridge.
- y) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- z) Provisional splinting, temporary procedures or interim stabilization.
- aa) Placement or removal of sedative filling, base or liner used under a restoration.
- bb) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
- cc) Occlusal procedures including occlusal guard.

- dd) Pulp vitality tests.
- ee) Adjunctive diagnostic tests.
- ff) Diagnostic casts.
- gg) Incomplete root canals.
- hh) Cone beam images.
- ii) Anatomical crown exposure.
- jj) Temporary anchorage devices.
- kk) Sinus augmentation.
- ll) Brush biopsy and the accession of a brush biopsy.
- mm) Restorations placed for preventive or cosmetic purposes.
- nn) Inlays, onlays and crowns placed for preventive or cosmetic purposes.
- oo) Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

Limitations

- a) **Optional Treatment Plans:** in all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Person and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.
- b) **Reconstructive Surgery:** benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, provided however, that such services are dental reconstructive surgical services.
- c) **Benefits for inpatient or outpatient expenses arising from dental services up to age 18, including orthodontic and oral surgery services, involved in the management of birth defects known as cleft lip and cleft palate.** For Programs without orthodontic coverage: Dental orthodontic services not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit program. For Programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this plan shall be primary and the other policy or contract shall be secondary.

For other dental procedure exclusions and limitations, refer to the Description of Coverages in this Dental Benefit Plan Summary.

Post Payment Review

Dental services are evaluated after treatment is rendered for accuracy of payment, benefit coverage and potential fraud or abuse as defined in the Health Insurance Portability and Accountability Act of 1996 - Public Law 102-191. Any payments for dental services completed solely for cosmetic purposes or payments for services not performed as billed are subject to recovery. Delta Dental's right to conduct post payment review and its right of recovery exists even if a Pretreatment Estimate was submitted for the service.

Optional Treatment Plans

In all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Person and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.

ELIGIBILITY

Covered Persons under this Program are:

Employees

- a) All eligible employees who have met the eligibility requirements as established by the Group and stated within this Dental Benefit Plan Summary under Effective Date of Coverage.
- b) Employees on Family and Medical Leave as mandated by the Federal FMLA.

Dependents

A) Spouse, meaning:

1. Married;
2. Legally separated;

B) Dependent children to the age of 26, including:

1. Natural-born and legally adopted children (including children placed with you for legal adoption. NOTE: A child's placement for adoption terminates upon the termination of the legal obligation of total or partial support.
2. Stepchildren who reside with you.
3. Grandchildren who are financially dependent on you and reside with you.
4. Children who are required to be covered by reason of a Qualified Medical Child Support Order. You can obtain, without charge, a copy of procedures governing Qualified Medical Child Support Orders ("QMCSOs") from the Plan Administrator.
5. Children who become handicapped prior to reaching the Plan's limiting age if:
 - they are primarily dependent upon you; and
 - are incapable of self-sustaining employment because of physical handicap, mental retardation, mental illness or mental disorders

NOTE: If both you and your spouse are employees of the employer, you may be covered as either an employee or as a dependent, but not both. Your eligible dependent children may be covered under either parent's coverage, but not both.

Effective Dates of Coverage

Eligible Employee:

You are eligible to be covered under this Program when the Program first became effective, September 1, 2015, or if you are a new employee of the Group, on the first (1st) of the month following your date of hire.

Eligible Dependents:

Your eligible dependents, as defined, are covered under this Program:

- a) On the date you first become eligible for coverage, if dependent coverage is provided or elected.
- b) On the date you first acquire eligible dependents, or add dependent coverage subject to the open enrollment requirements of the Group, if any.
- c) On the date a new dependent is acquired if you are already carrying dependent coverage.

LIMITATION: Dependents of an eligible employee who are in active military service are not eligible for coverage under the Program.

Children may be added to the Program at the time the eligible employee originally becomes effective or may be added anytime up to 30 days following the child's 3rd birthday. If a child is born or adopted after the employee's original effective date, such child may be added anytime between birth (or date of adoption) and 30 days following the child's 3rd birthday. In the event that the child is not added by 30 days following their 3rd birthday, that child may be added only if there is a Family Status Change or at the next Open Enrollment period, if any.

The eligibility of all Covered Persons, for the purposes of receiving benefits under the Program, shall, at all times, be contingent upon the applicable monthly payment having been made for such Covered Person by the Group on a current basis.

Open Enrollment

The Open Enrollment under this Contract shall be held annually.

Family Status Change

Your benefit elections are intended to remain the same for the entire Coverage Year. During the Coverage Year, you will be allowed to change your benefits only if you experience an eligible Family Status Change which includes:

- Change in legal marital status such as marriage or divorce.
- Change in number of dependents in the event of birth, adoption, or death.
- Change in your or your spouse's employment - either starting or losing a job.
- Change in your or your spouse's work schedule, such as going from full-time to part-time or part-time to full-time, or beginning or ending an unpaid leave of absence.
- Change in dependent status, if a child becomes or is no longer a full time student, or if a child reaches maximum age under the Plan.
- Change in residence or work location so you are no longer eligible for your current health plan.
- Qualification for Medicare or Medicaid.
- Qualification for or termination of, employment assistance under Medicaid or the Children's Health Insurance Program (CHIP).
- Loss of other coverage.

Due to federal regulations, the changes you make to your benefits must be consistent with the Family Status Change event that you experience. For example, if you have a baby, it is consistent to add your newborn to your current dental coverage but it is not consistent to drop your dental coverage altogether.

If you experience one of the above eligible Family Status Changes during the year, you have 31 days (except in the case of qualification for or termination of employment assistance under Medicaid/CHIP, in which case the employee has 60 days after the date of eligibility) from the event to change your elections. If you do not change your benefits within 31 days of the event, you will not be allowed to make changes until the next Open Enrollment period. You may obtain a Family Status Change Form by contacting your Employer. All changes are effective the date of the change.

Termination of Coverage

Your coverage and that of your eligible dependents ceases on the earliest of the following dates:

- a) The end of the month in which (1) you cease to be eligible; (2) your dependent is no longer eligible as a dependent under the Program.
- b) On the date the Program is terminated.
- c) On the date the Group terminates the Program by failure to pay the required Group Subscriber payments, except as a result of inadvertent error.

For extended eligibility, see Continuation of Coverage.

The Group or Plan Sponsor reserves the right to terminate the Plan, in whole or in part, at any time (subject to applicable collective bargaining agreements). Termination of the Plan will result in loss of benefits for all covered persons. If the Plan is terminated, the rights of the Plan Participants are limited to covered expenses incurred before termination.

Continuation of Coverage

Dental benefits may be continued should any of the following events (called Qualifying Events) occur, provided that at the time of occurrence this Program remains in effect and you or your spouse or your dependent child is a Covered Person under this Program.

QUALIFYING EVENT	WHO MAY CONTINUE	MAXIMUM CONTINUATION PERIOD
Employment ends, retirement, leave of absence, lay-off, or a reduction in hours that causes the employee to become ineligible (except gross misconduct dismissal)	Employee and dependents	Earliest of: 1. 18 months. 2. Enrollment in other group coverage. 3. Date coverage would otherwise end.
Divorce, marriage dissolution or legal separation	Former Spouse and any dependent children who lose coverage	Earliest of: 1. Enrollment date in other group coverage. 2. Date coverage would otherwise end.
Death of Employee	Surviving spouse and dependent children	Earliest of: 1. Enrollment date in other group coverage. 2. Date coverage would have otherwise terminated under the contract had the employee lived.

Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months. 2. Enrollment date in other group coverage. 3. Date coverage would otherwise end.
Dependents lose eligibility due to Employee's entitlement to Medicare	Spouse and dependents	Earliest of: 1. 36 months. 2. Enrollment date in other group coverage. 3. Date coverage would otherwise end.
Employee's total disability	Employee and dependents	Earliest of: 1. Date total disability ends. 2. Date coverage would otherwise end.
Retirees of employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within 1 year of filing)	Retiree and dependents	Earliest of: 1. Enrollment date in other group coverage. 2. Death of retiree or dependent electing COBRA.
Surviving Dependents of retiree on lifetime continuation due to the bankruptcy of the employer	Surviving Spouse and dependents	Earliest of: 1. 36 months following retiree's death. 2. Enrollment date in other group coverage.

You or your eligible dependents have 60 days from the date you lose coverage, due to one of the events described above, to inform the Group that you wish to continue coverage; except that, in the case of death of an eligible employee, such notification period to continue coverage shall be 90 days.

1. Choosing Continuation

If you lose coverage, due to a termination of employment (except if the termination is for gross misconduct), retirement, leave of absence, lay-off, or reduction in hours, your employer should notify you of the option to continue coverage within 10 days after your loss of coverage. You or your covered dependents must notify your employer of divorce, legal separation, or any other change in dependent status within 60 days of the event.

You or your covered dependents must choose to continue coverage by completing, in writing, the election notice that your employer sends to you. You or your covered dependents have 60 days to choose to continue, starting with the date of the notice of continuation or the date coverage ended, whichever is later. Failure to choose continuation within the required time period will make you or your covered dependents ineligible to choose continuation at a later date. You or your covered dependents have 45 days from the date of choosing continuation to pay the first continuation charges. After this initial grace period, you or your covered dependents must pay charges monthly in advance to the employer to maintain coverage in force.

Charges for continuation are the group rate plus a two percent administration fee. All charges are paid directly to your employer. If you or your covered dependents are totally disabled, charges for continuation are the group rate plus a two percent administration fee for the first 18 months. For months 19 through 29, the employer may charge the group rate plus a 50 percent administration fee.

2. Second qualifying event

If a second qualifying event occurs during continuation, a dependent qualified beneficiary may be entitled to election rights of their own and an extended continuation period. This rule only applies when the initial qualifying event for continuation is the employee's termination of employment, retirement, leave of absence, layoff, or reduction of hours.

When a second qualifying event occurs such as the death of the former covered employee, the dependent must notify the employer of the second event within 30 days after it occurs in order to continue coverage. In no event will the first and second period of continuation extend beyond the earlier of the date coverage would otherwise terminate or 36 months.

A qualified beneficiary is any individual covered under the health plan the day before the qualified event as well as a child who is born or placed for adoption with the covered employee during the period of continuation coverage.

3. Terminating Continuation of Coverage

Continuation of Coverage for you and your eligible dependents, if selected, shall terminate on the last day of the month in which any of the following events first occur:

- a) The expiration of the specified period of time for which Continuation of Coverage can be maintained; as mandated by applicable State or Federal law;
- b) This Program is terminated by the Group Subscriber;
- c) The Group Subscriber's or Covered Person's failure to make the payment for the Covered Person's Continuation of Coverage;

Questions regarding Continuation of Coverage should be directed to your employer. Your employer will explain the regulations, qualifications and procedures required when you continue coverage.

PLAN PAYMENTS

Participating Dentist Network

A Delta Dental Premier dentist is a dentist who has signed a participating and membership agreement with his/her local Delta Dental Plan. The dentist has agreed to accept Delta Dental's Maximum Amount Payable as payment in full for covered dental care. Delta Dental's Maximum Amount Payable is a schedule of fixed dollar maximums established solely by Delta Dental for dental services provided by a licensed dentist who is a participating dentist. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental Premier dentist has agreed not to bill more than Delta Dental's allowable charge. A Delta Dental Premier dentist has also agreed to file the claim directly with Delta Dental.

A Delta Dental PPO network dentist is a dentist who has signed Delta Dental PPO agreement with Delta Dental Plan of Minnesota. The dentist has agreed to accept the Delta Dental PPO allowable charge as payment in full for covered dental care. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental PPO dentist has agreed not to bill more than the Delta Dental PPO allowable charge. A Delta Dental PPO dentist has also agreed to file the claim directly with Delta Dental.

Listings of participating providers are available to Subscribers as a separate document and are furnished by the Group without charge. Names of Participating Dentists can be obtained, upon request, by calling Delta, from directory listings furnished to the Group or from the Plan's internet web site at www.deltadentalmn.org. Refer to the General Information section of this booklet for detailed information on how to locate a participating provider using the Plan's internet web site.

Covered Fees

Under this Program, YOU ARE FREE TO GO TO THE DENTIST OF YOUR CHOICE. You may have additional out-of-pocket costs if your dentist is not a Delta Dental Premier or a Delta Dental PPO dentist with the plan. There may also be a difference in the payment amount if your dentist is not a participating dentist with Delta. This payment difference could result in some financial liability to you. The amount is dependent on the nonparticipating dentist's charges in relation to the Table of Allowances determined by Delta.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN YOUR DELTA DENTAL PREMIER AND DELTA DENTAL PPO NETWORKS PRIOR TO RECEIVING DENTAL CARE.

Claim Payments

PAYMENTS ARE MADE BY THE PLAN ONLY WHEN THE COVERED DENTAL PROCEDURES HAVE BEEN COMPLETED. THE PLAN MAY REQUIRE ADDITIONAL INFORMATION FROM YOU OR YOUR PROVIDER BEFORE A CLAIM CAN BE CONSIDERED COMPLETE AND READY FOR PROCESSING. IN ORDER TO PROPERLY PROCESS A CLAIM, THE PLAN MAY BE REQUIRED TO ADD AN ADMINISTRATIVE POLICY LINE TO THE CLAIM. DUPLICATE CLAIMS PREVIOUSLY PROCESSED WILL BE DENIED.

ANY BENEFITS PAYABLE UNDER THIS PLAN ARE NOT ASSIGNABLE BY ANY COVERED PERSON OR ANY ELIGIBLE DEPENDENT OF ANY COVERED PERSON.

Delta Dental Premier Dentists:

Claim payments are based on the Plan's Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental Premier dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental Premier dentists is the lesser of: (1) The fee pre-filed by the dentist with their Delta Dental organization; (2) The Maximum Amount Payable as determined by Delta Dental; (3) The fee charged or accepted as payment in full by the Delta Dental Premier dentist regardless of the amount charged. All Plan Payment Obligations are determined prior to the calculation of any patient co-payments and deductibles as provided under the patient's Delta Dental program.

Delta Dental PPO Dentists:

Claim payments are based on the Plan's Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental PPO dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental PPO dentists is the lesser of: (1) The fee pre-filed by the dentist with their Delta Dental organization; (2) The Delta Dental PPO Maximum Amount Payable as determined by Delta Dental; (3) The fee charged or accepted as payment in full by the Delta Dental PPO dentist regardless of the amount charged. All Plan Payment Obligations are determined prior to the calculation of any patient co-payments and deductibles as provided under the patient's Delta Dental program.

Nonparticipating Dentists:

Claim payments are based on the Plan's Payment Obligation, which for nonparticipating dentists is the treating dentist's submitted charge or the Table of Allowances established solely by Delta Dental, whichever is less. The Table of Allowances is a schedule of fixed dollar maximums established by Delta Dental for services rendered by a licensed dentist who is a nonparticipating dentist. Claim payments are sent directly to the Covered Person.

THE COVERED PERSON IS RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY THE NONPARTICIPATING DENTIST. WHEN SERVICES ARE OBTAINED FROM A NON-PARTICIPATING PROVIDER, ANY BENEFITS PAYABLE UNDER THE GROUP CONTRACT ARE PAID DIRECTLY TO THE COVERED PERSON.

Coordination of Benefits (COB)

If you or your dependents are eligible for dental benefits under this Program and under another dental program, benefits will be coordinated so that no more than 100% of the "Allowable Charges" is paid jointly by the programs. "Allowable Charges", as defined above, are determined prior to calculating all percentages, deductibles and benefit maximums.

The Coordination of Benefits provision determines which program has the primary responsibility for providing the first payment on a claim. In establishing the order, the program covering the patient as an employee has the primary responsibility for providing benefits before the program covering the patient as a dependent. If the patient is a dependent child, the program with the parent whose month and day of birth falls earlier in the calendar year has the primary payment responsibility. If both parents should have the same birth date, the program in effect the longest has the primary payment responsibility. If the other program does not have a Coordination of Benefits provision, that program most generally has the primary payment responsibility.

NOTE: When Coordination of Benefits applies for dependent children, provide your dentist with the birth dates of both parents.

Claim and Appeal Procedures

Proof of Loss

All claims should be submitted within 12 months of the date of service. If you do not submit a claim within the time required, it will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. You must submit your proof as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Initial Claim Determinations

An initial benefit determination on your claim will be made within 30 days after receipt of your claim. You will receive written notice of this benefit determination. The 30-day period may be extended for an additional 15 days if the claim determination is delayed for reasons beyond our control. In that case, we will notify you prior to the end of the initial 30-day period. We will tell you the reasons we require an extension and the date by which we expect to make a decision. If the extension is needed for us to get additional information from you, the notice will describe the specific information we need. You will have 45 days from the receipt of the notice to provide the information. Without complete information, your claim will be denied.

Appeals

In the event that we deny a claim in whole or in part, you have a right to a full and fair review. Your request to review a claim must be in writing and submitted to us within 180 days from the claim denial. We will make a benefit determination within 60 days following receipt of your appeal.

Your appeal must include your name, your identification number, group number, claim number, and dentist's name as shown on the Explanation of Benefits. Send your appeal to:

Delta Dental of Minnesota
Attention: Appeals Unit
PO Box 551
Minneapolis, MN 55440-0551

You may submit written comments, documents, or other information that supports your appeal. Upon request, you will also be given reasonable access to and copies of all relevant records used in making the decision. These records will be given to you at no charge. The review will take into account all information about the denied or reduced claim, even if the information was not present or available at the time of the initial determination. In this review, the initial determination will not be given any weight.

The review will be done by someone different from the original decision-makers and will not take into consideration any prior decisions made in your claim. Because all decisions are based on a preset schedule of dental services that are covered by your plan, claims are not reviewed to determine dental necessity or appropriateness. If we need to consult a professional to determine if a service is covered under your plan's schedule of benefits, we will consult with a dental professional who has appropriate training and experience. This professional will not be the same person who was involved in the initial adverse benefit determination (nor a subordinate of any such person). We will identify any dental professional whose advice was obtained on our behalf, even if the advice was not used in making the benefit determination. If, after review, we continue to deny the claim, you will be notified in writing.

Authorized Representative

You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. However, no authorization is required for your treating dentist to make a claim or appeal on your behalf. The authorization form must be in writing, signed by you, and include all the information required in our Authorized Representative form. This form is available at our web site or by calling Customer Service. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

External review

If you consider Delta Dental's decision to be partially or wholly adverse to you, you have a right to submit a written request for external review to the Commissioner of Commerce at:

External Review Process
State of Minnesota Department of Commerce
85 7th Place East Street
St. Paul, MN 55101
(651) 539-1600 or 1-800-657-3602

An independent entity contracted with the State will review your request. The independent entity is impartial, separate from and has no affiliation with Delta Dental. The external review decision will not be binding on you but will be binding on Delta Dental. Contact the Commissioner of Commerce above for more information about the external review process or to file a request for a review.

GENERAL INFORMATION

Health Plan Issuer Involvement

Delta Dental is the health plan issuer involved with the Plan. It's address is stated on the back cover of this booklet. The benefits under the Plan are guaranteed by Delta Dental under the Contract (for insured plans).

Other than eligibility determinations, which are made by the Plan Sponsor, Delta Dental of Minnesota has the sole authority, discretion and responsibility to interpret and apply the terms of this Program and to determine all factual and legal questions under the Program, including the amount of benefits to be paid under the insurance contract, if any.

Privacy Notice

Delta Dental of Minnesota will not disclose non-public personal financial or health information concerning persons covered under our dental benefit plans to non-affiliated third parties except as permitted by law or required to adjudicate claims submitted for dental services provided to persons covered under our dental benefit plans.

How to Find a Participating Dentist

A real-time listing of participating dentists is available in an interactive directory at the Plan's user friendly web site, www.deltadentalmn.org. The Plan highly recommends use of the web site for the most accurate network information. Go to <http://www.deltadentalmn.org/findAdentist> and enter your zip code, city or state to find local participating dentists. You can also search by dentist or clinic name. The Web site also allows you to print out a map directing you to the dental office you select. **The Dentist Search is an accurate and up-to-date way to obtain information on participating dentists.**

To search for and verify the status of participating providers, select "Dentist Search" on the www.deltadentalmn.org home page. Select the Product or Network in the drop-down menu, and search by city and state, zip code or provider or clinic name. If your dentist does not participate in the network, you may continue to use that dentist, although you will share more of the cost of your care and could be responsible for dental charges up to the dentist's full billed amount.

If you do not have Internet access, other options are available to find a network dentist or verify that your current dentist is in the network.

- When you call to make a dental appointment, always verify the dentist is a participating dentist. **Be sure to specifically state that your employer is providing the Dental program.**
- Contact our Customer Service Center at: (651) 406-5901 or (800) 448-3815. Customer Service hours are 7 a.m. to 7 p.m., Monday through Friday, Central Standard Time.

Using Your Dental Program

Dentists who participate with Delta under this Program are independent contractors. The relationship between you and the participating dentist you select to provide your dental services is strictly that of provider and patient. Delta cannot and does not make any representations as to the quality of treatment outcomes of individual dentists, nor recommends that a particular dentist be consulted for professional care.

All claims should be submitted within 12 months of the date of service.

If your dentist is a participating dentist, the claim form will be available at the dentist's office.

If your dentist is nonparticipating, claim forms are available by calling:

National Dedicated Service Center - (651) 406-5901 or (800) 448-3815

The Plan also accepts the standard American Dental Association (ADA) claim form used by most dentists.

The dental office will file the claim form with the Plan; however, you may be required to assist in completing the patient information portion on the form (Items 1 through 14).

During your first dental appointment, it is very important to advise your dentist of the following information:

- * YOUR DELTA GROUP NUMBER
- * YOUR EMPLOYER (GROUP NAME)
- * YOUR IDENTIFICATION NUMBER (your dependents must use **YOUR** identification number)
- * YOUR BIRTHDAY AND THE BIRTH DATES OF YOUR SPOUSE AND DEPENDENT CHILDREN

Cancellation and Renewal

The Program may be canceled by the Plan only on an anniversary date of the Group Dental Plan Contract, or at any time the Group fails to make the required payments or meet the terms of the Contract.

Upon cancellation of the Program, Covered Persons of the Group have no right to continue coverage under the Program or convert to an individual dental coverage contract.

DELTA DENTAL OF MINNESOTA
500 Washington Avenue South, Suite 2060
Minneapolis, Minnesota 55415-1163
(651) 406-5959 or (800) 704-6993

**NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN
INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH
INSURANCE GUARANTY ASSOCIATION LAW**

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
4760 White Bear Parkway, Suite 101
White Bear Lake, MN 55110
(651)407-3149

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to \$500,000. Subject to this \$500,000 limit, the guaranty association will pay up to \$500,000 in life insurance death benefits, \$130,000 in net cash surrender and net cash withdrawal values for life insurance, \$500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, \$250,000 in annuity net cash surrender and net cash withdrawal values, \$410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be \$500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to \$250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than \$10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed \$10,000,000, the \$10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

DELTA DENTAL OF MINNESOTA

FOR CLAIMS AND ELIGIBILITY

National Dedicated Service Center
P.O. Box 59238
Minneapolis, Minnesota 55459
(651) 406-5901 or (800) 448-3815

CORPORATE LOCATION

500 Washington Avenue South, Suite 2060
Minneapolis, Minnesota 55415-1163
(651) 406-5900 or (800) 328-1188
www.deltadentalmn.org

CORPORATE MAILING ADDRESS

P.O. Box 9304
Minneapolis, Minnesota 55440-9304
(651) 406-5900 or (800) 328-1188

Approved 11/2015 (PDF only)