Delta Dental of Minnesota

Delta Dental Individual and Family[SM]

Adult Platinum + Kids Plan

Delta Dental Individual and Family[SM]- Adult Platinum + Kids Plan

Thank you for choosing Delta Dental to protect your smile!

This Dental Benefit Plan is an insurance policy covering certain dental benefits and is issued by Delta Dental of Minnesota, referred to as "Delta Dental" in this document. We consider this document our contract with "you"—the person who enrolled in this policy and is also known as the "subscriber." You, your spouse or any dependents on the policy, will be referred to as "covered persons" throughout this document.

This document is your policy, which is a contract for dental benefits coverage. It is important that you read this document and contact us if you have any questions. We also encourage you to keep this document for reference if you have questions about your dental benefits coverage.

The application you completed with your enrollment is part of this policy and was sent to us by MNsure. If any part of your application is wrong, please contact MNsure right away. Wrong information may affect your coverage. If the answers are incorrect or untrue, we may have the right to deny benefits or rescind your policy. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Delta Dental of Minnesota is the health plan that issued you this Dental Benefit policy. The benefits under this policy are guaranteed by Delta Dental of Minnesota under this contract. If you enrolled into this policy and had prior Individual and Family coverage through Delta Dental of Minnesota, we will review the claims that were previously incurred and submitted when we determine your benefits under this policy.

YOUR RIGHT TO EXAMINE AND CANCEL

You may cancel this contract by returning the contract, with written notification of your cancelation to Delta Dental of Minnesota, P.O. Box 1886, Indianapolis, IN 46206-1886. Cancelation notice must be given by mail and needs to be properly addressed, postage prepaid, and postmarked no later than **ten days** after you received this contract. Delta Dental will void your policy from its effective date. Delta Dental will also return the difference between any premiums paid by you and any benefits paid by Delta Dental on your behalf or on behalf of any of the covered persons under this contract.

DELTA DENTAL OF MINNESOTA

BY: Stephanie A. Albert

TITLE: Assistant Secretary

DATE: August 30, 2019

DELTA DENTAL OF MINNESOTA

AND BY: Rodney A. Young

TITLE: Chief Executive Officer and President

DATE: August 30, 2019

Table of Contents

IMPORTANT INFORMATION ABOUT YOUR POLICY 4

CONTRACT PROVISIONS (REQUIRED LEGAL NOTICES) 4

NOTICE OF NON-DISCRIMINATION AND ACCESSIBILITY REQUIREMENTS 7

FOREIGN LANGUAGE NOTIFICATIONS 8

DEFINITIONS 10

USING YOUR DENTAL PLAN 11

SUMMARY OF DENTAL BENEFITS FOR PEDIATRIC MEMBERS 15

DESCRIPTION OF COVERED SERVICES FOR PEDIATRIC MEMBERS 16

ORTHODONTIC CARE FOR PEDIATRIC MEMBERS 20

Dentally Necessary Orthodontic Care *20*

TEMPOROMANDIBULAR JOINT DISORDER (TMD) 21

RECONSTRUCTIVE DENTAL SURGERY 22

CLEFT LIP AND CLEFT PALATE 22

GENERAL EXCLUSIONS FOR PEDIATRIC MEMBERS 22

SUMMARY OF DENTAL BENEFITS FOR ADULT MEMBERS 24

DESCRIPTION OF COVERED SERVICES FOR ADULT MEMBERS 24

TEMPOROMANDIBULAR JOINT DISORDER (TMD) 28

RECONSTRUCTIVE DENTAL SURGERY 28

CLEFT LIP AND CLEFT PALATE 28

GENERAL EXCLUSIONS FOR ADULT MEMBERS 29

COORDINATION OF BENEFITS WITH WORKER'S COMPENSATION, FEDERAL MEDICARE, AND FEDERAL VETERAN'S ADMINISTRATION PROGRAMS 31

POST-PAYMENT REVIEW 31

ELIGIBILITY 31

EFFECTIVE DATES OF COVERAGE 33

OPEN ENROLLMENT 33

CHANGES AFFECTING ELIGIBILITY AND SPECIAL ENROLLMENT 34

TERMINATION OF COVERAGE 35

RENEWABILITY 35

CLAIM PROVISIONS 35

CLAIMS AND APPEAL PROCEDURES 36

DELTA DENTAL OF MINNESOTA NOTICE OF PRIVACY PRACTICES 38

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW 41

IMPORTANT INFORMATION ABOUT YOUR POLICY

Delta Dental Individual and Family Policy
Delta Dental of Minnesota (referred to as "Delta Dental" throughout this document) will pay the benefits described in this policy, subject to its provisions. This policy is a legal contract between "you," the subscriber, and Delta Dental. This policy is intended to insure only Minnesota residents and is subject to the laws of the State of Minnesota.

Premium Payment
Premiums, the amount due for this policy, must be paid by you on a monthly basis, unless Delta Dental agrees to some other schedule of payment. By paying your first premium, you agree to the terms of this policy and to pay all of your premiums when due. Premiums may be paid electronically or mailed to Delta Dental at the following address:

Delta Dental of Minnesota
PO Box 74008400
Chicago, IL 60674-8400

Payment of your premium is required to start and keep your coverage. We understand that sometimes things happen, so we have a grace period of up to 90 days for the payment of your premiums (this is only in effect after you have made your first premium payment). Should you need to take advantage of the grace period, your coverage under this policy will continue, but you will be liable for the premium accumulated during the grace period. Failure to pay the full premium by the end of the 90-day grace period will result in the termination of your coverage. Your termination will be back dated to the end of the month through which your premium was paid.

Annual Benefit Coverage and Premium Review
Each year—on January 1—Delta Dental may make updates to our dental insurance plans to ensure they are compliant with the State of Minnesota and the Affordable Care Act as well as to meet business and changing market demands. This may include changes in the benefits or premium rates for the insurance coverage under this policy. If we make any changes, we must provide you with written notice of these changes at least 31 days prior to any change being in effect.

CONTRACT PROVISIONS (REQUIRED LEGAL NOTICES)

1. **Entire Contract:** This Contract, the application of the Policyholder (a copy attached to this Policy), the individual enrollment forms, if any and the Benefit Plan Summary will constitute the entire contract between the Policyholder and Delta Dental. All statements made by the Policyholder will be deemed representations and not warranties.

No agent or other individual except Delta Dental's President or Senior Vice President has the authority to make or modify this Contract or extend the time for payment of any premium. No change in this Contract will be valid unless made by endorsement or amendment signed by the Policyholder and Delta Dental's President or a Senior Vice President and attached to this Contract. Any change so made will be binding on the Policyholder and on any other person(s) referred to in this Policy.

2. **Health Plan Issuer Involvement:** Delta Dental of Minnesota is the health plan that issues you this Dental Insurance policy. Our address is stated on the back cover of this booklet. The benefits provided under this policy are guaranteed by Delta Dental of Minnesota under this contract. If you and your covered persons had prior coverage with Delta Dental of Minnesota, we will review the claims incurred and submitted when determining benefits under this policy.

3. **Legal Actions:** No action at law or in equity shall be brought to recover on this contract prior to the expiration of 60 days after written proof of loss has been furnished in accordance with this contract. No such action will be brought after the expiration of three years after written proof of loss is required to be furnished.

4. **Conflict with Existing Law:** In the event that any provision of this contract is in conflict with Minnesota or federal law, only that provision is hereby amended to conform to the minimum requirements of the law.

5. **Clerical Error:** If routine processing delays or clerical errors occur, they will not deprive you of coverage for which you are otherwise eligible, nor will they give you coverage under this contract for which you are not eligible under this contract.

6. **Misstatement of Age:** If the age of the insured has been misstated, all amounts payable from the subscriber under this policy shall be adjusted to reflect the premium amount paid by the subscriber for the correct age at the time of purchase.

7. **Contract Term:** This contract continues until December 31 each year, as long as your premium is paid, subject to the grace period. The contract may be renewed thereafter by Delta Dental or the Subscriber.

8. **Termination or Cancelation of Policy:** You may cancel this policy by notifying MNsure of your intent to cancel. When notice is given, the cancelation date can be effective as soon as the first of the following month, but MNsure will make the final determination to establish the effective date of the cancelation.

   Delta Dental reserves the right to terminate this policy effective at the end of the contract term in accordance with applicable law. Termination or cancelation of the policy will result in loss of benefits for all covered persons. If the policy is terminated or

canceled, the rights of the covered persons are limited to covered expenses incurred before termination or cancelation.

9. **Time Limit on Certain Defenses:** After two (2) years from the issue date for this policy, no misstatements, except fraudulent misstatements, made by the applicant in the enrollment form for this policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in this policy, starting after the end of such two (2) year period.

10. **Reinstatement:** If you do not make a premium payment in the allotted grace period, a subsequent acceptance of premium by Delta Dental or by an agent duly authorized by Delta Dental to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy, except that if Delta Dental or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by Delta Dental or, lacking such approval, upon the forty-fifth (45) day following the date of such conditional receipt unless Delta Dental has previously notified you in writing of its disapproval of such application.

    Upon reinstatement, Delta Dental and you shall have the same rights as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed or attached in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid.

11. **Physical Examination and Autopsy:** Delta Dental, at its own expense, shall have the right to examine the covered person as often as it may reasonably require during the pending of a claim and to make an autopsy in case of death, where it is not forbidden by law.

12. **Change of Beneficiary:** The right to change of beneficiary is reserved to the Subscriber. The consent of the beneficiary or beneficiaries shall not be required to surrender or assignment of this policy, or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

13. **Privacy Other than HIPAA:** 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 policies. Please see the Notice of Privacy Practices at the back of this booklet for HIPAA information.

NOTICE OF NON-DISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

Delta Dental of Minnesota complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Delta Dental of Minnesota does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Delta Dental of Minnesota provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats)

Delta Dental of Minnesota provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call the phone number on the back of your ID card.

If you believe Delta Dental of Minnesota has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by contacting us by phone at 612-224-3300 or 877-268-3384; by fax at 612-460-3102; email: legal@deltadentalmn.org; or by mail at:

Delta Dental of Minnesota
Attn: Chief Compliance Officer
500 Washington Avenue South, Suite 2060
Minneapolis, MN, 55415

You may file a grievance in person or by mail, fax or email. If you need help filing a grievance, please call the number on the back of your ID card.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal available online at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

You may also contact them by phone at 1-800-368-1019, 1-800-537-7697 (TDD). You may contact them by mail at:

U.S Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

FOREIGN LANGUAGE NOTIFICATIONS

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-643-3582 (TTY: 711). (Spanish)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-643-3582 (TTY: 711). (Hmong)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-643-3582 (TTY: 711). (Cushite)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-643-3582 (TTY: 711). (Vietnamese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-643-3582 (TTY: 711). (Chinese)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-643-3582 (телетайп: 711). (Russian)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-643-3582 (TTY: 711). (Laotian)

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-643-3582 (መስማትለተሳናቸው: 711). (Amharic)

ဟ်သူဉ်ဟ်သး– နမ့ါကတိၤ ကညီ ကျိာ်အယိ. နမၤနှ့ါ ကျိာ်အတ်မၤစၢၤလ၊ တလၫ်ဘူဉ်လၫ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1-855-643-3582 (TTY: 711). (Karen)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-643-3582 (TTY: 711). (German)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. برقم اتصل 1-855-643-3582 رقم. (711): ه الصم والبكم (Arabic)

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-643-3582 (ATS: 711). (French)

주의:한국어를사용하시는경우,언어지원서비스를무료로이용하실수있습니다 1-855-643-3582 (TTY: 711)번으로전화해주십시오.(Korean)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-643-3582 (TTY: 711). (Tagalog)

(Kurdish) تۆ بۆ ،بەخۆڕایی ،زمان یارمەتی خزمەتگوزاریەکانی ،دەکەیت قسەکوردی زمانی بە ئاگاداری: پەیوەندی بکە. (TTY: 711) 1-855-643-3582

بگیرید. شما برای رایگان بصورت زبانی تسهیلات ،کنید می گفتگو فارسی زبان به اگر توجهف می باشد .با (TTY: 711) 1-855-643-3582 تماس(Persian / Farsi):

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-643-3582 (TTY: 711) まで、お電話にてご連絡ください。(Japanese)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-855-643-3582 (TTY: 1-711). (Bantu)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-855-643-3582 (TTY: 711). (Swahili)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-855-643-3582 (TTY: 711). (Norwegian)

សូមប្រុងប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយភាសាដោយឥតគិតថ្លៃ, ដែលអ្នកអាចប្រើប្រាស់បាន។ សូមហៅទូរស័ព្ទ 1-855-643-3582 (TTY: 711) (Cambodian/Khmer)

ध्यानाकर्षण: यदि तपाईं [नेपाली] बोल्नुहुन्छ भने, नि:शुल्क रूपमा तपाईंलाई भाषा सहायता सेवाहरू उपलब्ध छन्। 1-855-643-3582 (TTY: 711) मा कल गर्नुहोस्। (Nepali)

DEFINITIONS

Please find the definitions to commonly used terms related to dental insurance or dental services. Additional definitions can be found by going to www.DeltaDentalMN.org.

Annual Maximum- the maximum dollar amount a dental plan will pay toward the cost of dental care within a specific benefit period. Most insurance plans have an annual and/or lifetime dollar maximum. The patient is responsible for paying costs above the plan maximum.

Annual Out of Pocket Maximum – the maximum amount for which the covered person will have to pay towards the costs of covered dental care. Delta Dental will pay the costs for covered Benefits above this amount. In the event that the out of pocket maximum is met, the Subscriber is responsible for paying the monthly premiums for the coverage to continue under the policy.

Benefits – covered dental services provided under the terms of this policy.

Calendar Year – the 12 months of the year from January 1 through December 31.

Coinsurance – the percentage of costs of a covered dental service you pay.

Coverage Year – the 12-month period in which deductibles and benefit maximums apply.

Covered Child/ren – covered person(s) on this policy whose age is from birth through the end of the year in which they turn 19 (except if their birthday is January 1).

Covered Person(s) – the subscriber and any spouse or other dependents that are covered under this policy.

Deductible – during a benefit period, you will have to personally pay a portion of your dental bill before your insurance carrier will contribute to your bill.

Dentist – any person who is appropriately licensed and qualified to practice dentistry under the law of the jurisdiction in which the dental procedure is performed and is operating within the scope of his/her license.

Exchange – another term for the Health Insurance Marketplace, a service available in every state that helps individuals, families, and small businesses shop for and enroll in affordable medical and dental insurance.

Explanation of Benefits (EOB) – a statement sent to subscriber by Delta Dental explaining how the payment amount for a dental benefit claim was calculated. The statement outlines the procedures covered by the subscriber's dental benefit policy and the amount, if any, that the insurer has paid toward the services and the remaining amount owed by the subscriber.

Maximum Allowable Fee – the amount a participating provider agrees to accept as payment in full for services rendered.

MNsure - Minnesota's health insurance marketplace found online at MNsure.org.

Policy Benefit Level – dental treatments are grouped into levels. The percentage covered by your dental plan often varies by benefit level.

Premium – the amount the enrollee pays for their dental benefits, usually paid monthly or annually.

Provider – a person licensed to practice dentistry when and where the services are performed. A provider shall also include a dental partnership, dental professional corporation, or dental clinic.

Provider Submitted Procedure Cost – the amount the provider bills and enters on a claim form for a specific procedure.

Subscriber – the person who has signed up for dental coverage from Delta Dental. If family coverage is offered, additional people covered will be listed as the subscriber's spouse or dependents.

Waiting Period - the time period that a covered person must for certain services to be covered benefits under this policy.

USING YOUR DENTAL PLAN

1. **The Dentist's Role:** Dentists who participate with Delta Dental under this policy are independent contractors. The relationship between you and the participating dentist you select to provide your dental care is strictly that of provider and patient. Delta Dental 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.

2. **Claims:** All claims should be submitted within twelve (12) months of the date of service. If your dentist is a participating dentist, the dentist will submit your claim on your behalf. The dental office will file the claim form with Delta Dental; however, you may be asked to assist in completing the patient information portion of the form (items 1 through 14). If the dentist is non-participating, claim forms are available by calling 855-643-3582 or by visiting our website at DeltaDentalMN.org. We also accept the standard American Dental Association (ADA) claim form.

3. **How to Find a Delta Dental Participating Dentist:** Dentists who have agreed to provide treatment to patients covered by a Delta Dental policy are called 'Participating' Dentists.

For your policy, participating dentists may be either Delta Dental Premier® or Delta Dental PPO℠ dentists.

Delta Dental Premier® Dentists- Delta Dental Premier dentists have agreed to accept the Maximum Allowable Fees in our Delta Dental Premier provider agreement for the services they provide.

Delta Dental PPO℠ Dentists- Delta Dental PPO dentists have agreed to accept the Maximum Allowable Fees in our Delta Dental PPO provider agreement. The Delta Dental PPO Maximum Allowable Fees are typically less than the Delta Dental Premier network. Because of this, selecting a Delta Dental PPO dentist may be a more cost-effective option for you.

When you select either a Delta Dental Premier or Delta Dental PPO dentist, they will complete and submit claim forms, and receive payment directly from Delta Dental of Minnesota on your behalf. You will not be charged more than the participating dentist's Maximum Allowable Fee. You will be responsible only for the coinsurances, deductibles, any amount over the plan annual maximum and for any care you choose to receive outside the covered services.

Choosing a Dentist: You may choose any dentist to provide services under this plan; however, if you choose a Delta Dental PPO dentist your costs may be lower than if you were to choose a dentist who is not a Delta Dental PPO dentist.

Example:
This chart shows a comparison of how your out-of-pocket costs are impacted by your selection of a Delta Dental PPO dentist, a Delta Dental Premier dentist, or a dentist who is not participating (also referred to as non-participating or out-of-network) in one of our networks.

Delta Dental of Minnesota's payment for covered services in this example is 50%.

Type of Provider	Provider Submitted Procedure Cost	Maximum Allowable Fee	What Delta Dental Pays	**Your Out of Pocket Cost**
Delta Dental PPO dentist	$600	$364.50	$182.25	$182.25
Delta Dental Premier dentist	$600	$462.50	$231.25	$231.25
Non-Participating dentist	$600	$352.50	$176.25	$423.75**

***Note:** We have no control over the fees a non-participating dentist may charge. You are responsible for paying the difference between Delta Dental of Minnesota's allowable fee and the fees charged by the Non-Participating dentist.*

To see if your dentist is a participating dentist, or to find a new participating dentist, visitDeltaDentalMN.org/find-a-dentist. We highly recommend using the website for network information. You can search for providers by ZIP code, address or by your currentlocation. You can also search by clinic or provider name.

If you do not have access to the website, you may also contact our Customer Service team at 855-643-3582, Monday through Friday between 7 a.m. and 7 p.m., central time.

While we work very hard to ensure our directories are up-to-date, care providers can make changes. Accordingly, when scheduling your appointment with your oral care professional, we encourage you to confirm that provider is still in your network.

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.

4. **Your First Appointment:** During your first dental appointment, it is very important to advise your dentist of the following information:
   - Your Delta Dental Group Number
   - Your Identification Number (your dependents must use **YOUR** identification number)
   - The date of birth for yourself, your spouse and any dependent children

5. **Pre-Treatment Estimates (Estimate of Benefits):** If a covered person's dental care involves major restorative, periodontic, prosthodontic, implant or orthodontic care, you or your dentist should consider getting a pre-treatment estimate from Delta Dental.
   - While a pre-treatment estimate is recommended, it is not required.
   - If you or your dentist request a pre-treatment estimate, you and your dentist will be informed of what benefits you have and if the treatment is a covered service via a pre-treatment estimate statement.
   - The pre-treatment estimate will detail the allowable amount we have contracted with participating dentists as payment for the applicable service.
   - The pre-treatment estimate statement will also outline amounts you will have to pay to the dentist, such as coinsurance, deductibles, any portion of the allowable amount you will owe and non covered services.
   - Delta Dental will respond to the pre-treatment estimate within 10 business days of receiving a complete request.
   - The pre-treatment estimate allows the dentist and you to make any necessary financial arrangements before your treatment begins.
   - Please be aware that pre-treatment estimates do not prior authorize the treatment, nor determine its dental or medical necessity, except in the case of pediatric orthodontic treatment (see "Dental Necessity" below). The estimated payment is based on your current eligibility and contract benefits in effect at the time of the estimate.
   - A pre-treatment estimate 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 coverage, or other coverage you have may alter the payment.

6. **Benefits:** This policy covers the following procedures when they are lawfully performed by or under the appropriate supervision of a duly licensed dentist or physician and when customary as determined by the standards of generally accepted dental practice.

   ONLY the services listed in this policy are covered. Services covered are subject to the limitations and exclusions as described in this booklet. If there is more than one professionally acceptable treatment for your dental condition, and the policy otherwise covers the services, the policy will cover the least expensive.

7. **Dental Necessity:** Delta Dental does not determine whether a service submitted for payment or benefit under this policy is a dental procedure that is dentally necessary to treat for a specific condition or to restore dentition for a covered person (except for orthodontic services as described below).
   - Delta Dental evaluates dental procedures submitted to determine if the procedure is a covered benefit under the policy.
   - A dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this policy. While these services may be necessary for a covered person's dental condition, they may not be covered by the policy.
   - Services that are not covered by the policy or exceed the frequency limitations do not imply that the service is or is not dentally necessary to treat a specific dental condition.
   - The decision as to what dental care treatment is best for you is solely between the covered person and his or her dentist.

   EXCEPTION: Claims for pediatric orthodontic care will be reviewed to determine if the care is Dentally Necessary Orthodontic Care. See the "Orthodontic Care" section of this booklet for more information. If it is determined the care is not Dentally Necessary Orthodontic Care, it will not be covered.

8. **Optional Treatment Options:** 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 cover person and the dentist. However, the benefits payable 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.

9. **Teledentistry:** Covered services include those provided to you by a dentist by way of Teledentistry. Any separate charge for teledentistry is not covered as the fees for transmitting data via teledentistryare considered inclusive in the overall dental procedure(s) being performed.

SUMMARY OF DENTAL BENEFITS FOR PEDIATRIC MEMBERS

Pediatric Dental Benefits
In order to be eligible for pediatric dental benefits, a covered person must be under the age of 19 at the time the annual policy is issued or renewed. Such covered person is referred to below as the "covered child/ren."

Annual Out-of-Pocket Maximum for covered services for Participating Dentists	$350 per covered child/ $700 per covered children in family
Annual Maximum for covered services for Non-Participating Dentists	$1,000 per covered child
Deductible (does not apply to Diagnostic and Preventive Services)	$50 per covered child per year
Dentally Necessary Orthodontic Care Policy Maximum (per course of treatment)	none

Summary of Services **Policy Benefit Level Payment Percentage**

Service Type	Participating Dentist	Non-Participating Dentist
Diagnostic and Preventive Services (deductible does not apply)	100%	100%
Basic Services	50%	50%
Endodontics/ Periodontics/Oral Surgery	50%	50%
Major Restorative Services	50%	50%
Prosthodontics	50%	50%
Implant Services	50%	50%
Dentally Necessary Orthodontic Care	50%	50%

Annual Maximum for Non-Participating Dentists: The policy pays up to $1,000 per covered child when covered services are received from a non-participating dentist. Unused annual maximums may not be carried over to future coverage years.

Deductible: There is a $50 deductible per Covered Child each Coverage Year. The deductible is the responsibility of the subscriber before the policy will pay out benefits. The deductible does not apply to Diagnostic and Preventive Services.

Coverage Year: Your coverage year is January 1 through December 31. A Coverage Year is a 12-month period in which deductibles and annual maximums apply. If you enroll after January 1, the coverage year for your first year will be from your effective date through December 31 and will begin again the following January 1.

DESCRIPTION OF COVERED SERVICES FOR PEDIATRIC MEMBERS

We cover the following dental care services for covered children through the year in which the covered child turns 19 years of age.

Diagnostic and Preventive Services for pediatric members

Oral Evaluations:	Any type of evaluation (check-up or exam) is covered 2 times per calendar year. There is no limitation on problem focused, detailed and extensive oral evaluations.
Radiographs (X-rays)/ imaging:	• Bitewings- Covered 2 times per calendar year. • Full Mouth (Complete Series)- Covered 1 time per 60-month period. • Panoramic- Covered 1 time per 60-month period. • Intraoral- Periapical and Occlusal • 2D Cephalometric Images • 2D Oral/Facial Photographic Images • Interpretation of Diagnostic Images
Dental Cleanings (Prophylaxis):	Covered 2 times per calendar year.
Fluoride Treatment (topical application of fluoride):	Covered 2 times per calendar year.
Fluoride Varnish:	Covered 2 times per calendar year.
Sealants:	Covered 1 time per 24-month period for permanent molars.
Preventive Resin Restorations:	Covered 1 time per 24-month period for permanent teeth.
Emergency Treatment:	Emergency (palliative) treatment for the temporary relief of pain or infection.
Other covered diagnostic and preventive services	• Diagnostic Casts • Space Maintainers • Recement Space Maintainers

Basic Services for pediatric members

Amalgam Restoration (silver fillings):	Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.
Composite Resin Restorations (white fillings):	Treatment to restore decayed or fractured permanent or primary teeth. • Posterior (back) Teeth: Benefits will be limited to those of an amalgam (silver filling). The Covered Person will be responsible for the difference in cost between what the policy allows for silver fillings, and what is charged for more costly fillings, plus the deductible and coinsurance.

Periodontal Maintenance:	Any combination of this procedure and dental cleanings (see Diagnostic and Preventive Services section) is covered 4 times per calendar year.
Periodontal Scaling & Root planing:	Covered 1 time per quadrant per 24 months.
Resin-Based Composite Resin Crown, Anterior:	Covered 1 time per 60-month period.
Pre-fabricated or Stainless-Steel Crown:	Covered 1 time per 60-month period.
Partial Pulpotomy for Apexogenesis:	Covered 1 time per lifetime on permanent teeth only.
Occlusal Guards:	Covered 1 per 12 months for covered person age 13 and older.
Resin Infiltration of Incipient Smooth Surface Lesions	Covered 1 time every 36 months.
General Anesthesia, Deep Sedation and Intravenous Conscious Sedation:	Covered only when performed in conjunction with complex services.
Other covered basic services	• After hours Office Visits • Consultations (other than dentist providing treatment) • Pin Retention • Therapeutic Drug Administration • Protective Restoration • Repairs to Crowns, Inlays, and Onlays

Endodontics for pediatric members

Endodontic Therapy on Primary Teeth:	• Pulpal Therapy • Therapeutic Pulpotomy
Complex Endodontic Surgical Services:	• Apicoectomy • Root amputation • Hemisection
Other covered endodontic services:	• Pulpal regeneration • Apexification • Endodontic Therapy (Root Canal) • Endodontic Retreatments

Periodontics for pediatric members

Full mouth debridement:	Covered 1 time per lifetime.
Complex Surgical Periodontal Care:	• Gingivectomy/ gingivoplasty • Gingival flap • Apically positioned flap • Crown Lengthening

	• Osseous surgery • Bone replacement graft • Pedicle soft tissue graft • Free soft tissue graft • Subepithelial connective tissue graft • Soft tissue allograft • Distal/proximal wedge- Covered on natural teeth only LIMITATION: The above surgical periodontal services are covered 1 time per 36-month period per single permanent tooth or multiple teeth in the same quadrant.
Other covered periodontic services:	Combined connective tissue and double pedicle graft

Oral Surgery for pediatric members

Basic Extractions:	• Removal of coronal remnants on primary teeth • Extraction of erupted tooth or exposed root
Complex Surgical Extractions:	• Surgical removal of erupted tooth • Surgical removal of impacted tooth • Surgical removal of residual tooth roots • Coronectomy
Other Complex Surgical Procedures:	• Alveoloplasty • Vestibuloplasty • Removal of exostosis-per site • Surgical reduction of osseous tuberosity • Bone replacement graft for ridge preservation • Excision of periocornal gingiva • Tooth reimplantation- accidentally evulsed or displaced tooth • Incision and drainage of abscess (intraoral soft tissue) • Suture of recent small wounds up to 5 cm • Complicated suturing • Exposure of an Unerupted tooth
Collect- Apply Autologous Product:	Covered 1 time per 36-month period.

Major Restorative Services for pediatric members

Gold Foil Restorations:	Benefits will be limited to those of an amalgam (silver filling). The Covered Person will be responsible for the difference in cost between what the policy allows for silver fillings, and what is charged for more costly fillings, plus the deductible and coinsurance.

Inlays:	Benefits will be limited to those of an amalgam (silver filling). The Covered Person will be responsible for the difference in cost between what the policy allows for silver fillings, and what is charged for more costly fillings, plus the deductible and coinsurance.
Onlays and/or Permanent Crowns:	Covered 1 time per 5-year period per tooth if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only.
Recement Inlay, Onlay and Crowns:	Covered 6 months after initial placement.
Crown/Inlay/Onlay Repair:	Covered when the submitted narrative from the treating dentist supports the procedure.
Prefabricated post and core in addition to crown:	Covered 1 per tooth every 60 months.
Other covered major restorative services:	• Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface • Veneer repair

Prosthodontics for pediatric members

Removable Prosthetic Services (Dentures and Partials):	Covered 1 time per 5-year period: • If 5 years have elapsed since the last covered removable prosthetic appliance, replacements will be covered only if the existing appliance cannot be repaired or adjusted.
Fixed Prosthetic Services (Bridge)	Covered 1 time per 5-year period: • If no more than 3 teeth are missing in the same arch; • If none of the individual units of the bridge has been covered previously as a crown or a cast restoration in the last 5 years; • If 5 years have elapsed since the last covered bridge, replacements will be covered only if the existing bridge cannot be repaired or adjusted.
Replacement of Broken Artificial Teeth:	• When the prosthetic appliance is the permanent prosthetic appliance; and • Only after 6 months following initial placement of the prosthetic appliance; and • When the submitted narrative from the treating dentist supports the procedure.
Reline and Rebase:	Covered 1 per 36-month period: • When the prosthetic appliance is the permanent prosthetic appliance; and

	• Only after 6 months following initial placement of the prosthetic appliance
Other covered prosthodontic services	• Denture Adjustments • Partial and Bridge Adjustments • Recement Fixed Prosthetic • Tissue Conditioning • Repairs to Dentures, Partials, Bridges, or Implants

Implant Services for pediatric members

Single Tooth Implant Body, Abutment and Crown:	Covered 1 time per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown. • Some adjunctive implant services may not be covered. It is recommended that a pre-treatment estimate be requested to estimate the amount of payment prior to beginning treatment.

ORTHODONTIC CARE FOR PEDIATRIC MEMBERS

Orthodontic treatment is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover orthodontic care that is considered Dentally Necessary Orthodontic Care. You and your oral health practitioner should submit the treatment plan to us before you start any orthodontic treatment to make sure it is covered under this policy.

Dentally Necessary Orthodontic Care

To be considered Dentally Necessary Orthodontic Care, at least one of the following criteria must be present:

a) Dentition affected by significant clef lip/palate, craniofacial or developmental disorder
b) Significant skeletal disharmony requiring a combination of orthodontic and orthognathic surgery for correction
c) Overjet greater than 9mm or reverse overjet greater than 3.5 mm
d) Anterior open bite greater than 4mm
e) Demonstrated functional impairment caused by unusual eruption patterns, severe crowding and/or unusual tooth formation

Orthodontic Treatment May Include the Following:

Limited Treatment:	Treatments which are not full treatment cases and are usually done for minor tooth movement.
Interceptive Treatment:	A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.

Comprehensive (complete) Treatment:	Full treatment includes all radiographs, diagnostic casts/models, appliances and visits.
Removable Appliance Therapy:	An appliance that is removable and not cemented or bonded to the teeth.
Fixed Appliance Therapy:	A component that is cemented or bonded to the teeth.
Complex Surgical Procedures:	Surgical exposure of impacted or unerupted tooth for orthodontic reasons; or surgical repositioning of teeth.

Note: Treatment in progress (appliances placed prior to being covered under this policy) will be benefited on a pro-rated basis.

Orthodontic Exclusions: Coverage is NOT provided for:

- Monthly treatment visits that are inclusive of treatment cost;
- Repair or replacement of lost/broken/stolen appliances;
- Orthodontic retention/retainer as a separate service;
- Retreatment and/or services for any treatment due to relapse;
- Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
- Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments: Because orthodontic treatment normally takes place over a long period of time, payments for benefits are made over the course of treatment. The covered person must continue to be eligible under the policy in order to receive ongoing payment for orthodontic benefits.

Before treatment begins, the treating dentist should submit a pre-treatment estimate. An estimate of benefits statement will be sent to you and your dentist that will tell you the estimated plan payment amount.

TEMPOROMANDIBULAR JOINT DISORDER (TMD)

Dental treatment that is considered surgical or non-surgical treatment of temporomandibular joint disorder (TMD) and craniomandibular disorder, including splints, is covered as required by Minnesota Statutes Section 62A.043 Subd. 3. A Pre-treatment Estimate of Benefits is recommended for such treatment.

Dental services for TMD will be covered under this dental Plan within the applicable Plan limitations, maximums, deductibles and payment percentages of treatment costs.

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

RECONSTRUCTIVE DENTAL SURGERY

Benefits shall be provided for reconstructive dental surgery when such dental procedures are (i) incidental to or follow surgery resulting from injury, illness or other diseases of the involved part, or (ii) 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. Such coverage is provided within the applicable Plan limitations, maximums, deductibles and payment percentages and to the extent required by Minnesota Statute 62A.25.

CLEFT LIP AND CLEFT PALATE

Inpatient or outpatient dental expenses arising from dental treatment up to age 19, 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. Benefits for individuals age 19 up to the limiting age for coverage of the dependent are limited to inpatient or outpatient expenses arising from dental treatment that was scheduled or initiated prior to the dependent turning age 19.

GENERAL EXCLUSIONS FOR PEDIATRIC MEMBERS

In addition to specific exclusions and limitations listed in other sections of this Summary of Dental Benefits, coverage is NOT provided for:

1) Dental services or health care services are not specifically covered under the policy (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).
2) New, experimental, or investigational dental techniques or services may be denied until there is, to the satisfaction of Delta Dental, an established scientific basis for recommendation.
3) 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 you are responsible for the full charge.
4) Dental services completed prior to the date the covered person became eligible for coverage.
5) Services for anesthesiologists.
6) Anesthesia services, except by a dentist or by an employee of a 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.
7) Analgesia, analgesic agents, anxiolysis nitrous oxide, or drugs for non-surgical or surgical dental care.
8) Dental services performed other than by a licensed dentist, licensed physician, or his or her employees.

9) 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.
10) Artificial material implanted or grafted into or onto bone or soft tissue, including implant services and associated fixtures, or surgical removal of implants, except as stated as covered in the sections above.
11) Services or supplies that have the primary purpose of improving the appearance of teeth. This includes, but is not limited to, tooth whitening agents or tooth bonding and veneer covering of the teeth.
12) Case presentations and office visits.
13) Incomplete, interim or temporary services.
14) Athletic mouth guards, enamel microabrasion and odontoplasty.
15) Bacteriologic tests.
16) Cytology sample collection.
17) Separate services billed when they are an inherent component of a dental service where the benefit is reimbursed at the Maximum Allowable Fee.
18) Interim or temporary removable or fixed prosthetic appliances (dentures, partials, or bridges).
19) Additional, elective or enhanced prosthetic procedures including but not limited to, connector bar(s), stress breakers, and precision attachments.
20) Provisional splinting, temporary procedures or interim stabilization.
21) Placement or removal of sedative filling, base or liner used under a restoration.
22) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
23) Oral hygiene instruction.
24) Occlusal procedures.
25) Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
26) Pulp vitality tests.
27) Adjunctive diagnostic tests.
28) Incomplete root canals.
29) Cone beam images.
30) Anatomical crown exposure.
31) Temporary anchorage devices.
32) Sinus augmentation.
33) Brush biopsy and the accession of a brush biopsy.
34) Restorations placed for cosmetic purposes.
35) Inlays, onlays, and crowns place for cosmetic purposes.
36) 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.

SUMMARY OF DENTAL BENEFITS FOR ADULT MEMBERS

Adult Dental Benefits
In order to be eligible for adult dental benefits, a covered person will be 19 or older at the time the annual policy is issued or renewed.

Annual Maximum for covered services	$1,200 per covered person
Deductible (does not apply to Diagnostic and Preventive Services)	$50 per covered person per year

Summary of Services **Policy Benefit Level Payment Percentage**

Service Type	Participating Dentist	Non-Participating Dentist
Diagnostic and Preventive Services	100%	100%
Basic Services	80%	80%
Endodontics/ Periodontics/Oral Surgery	50%	50%
Major Restorative Services*	50%	50%
Prosthodontics*	50%	50%
Implant Services*	50%	50%
Dentally Necessary Orthodontic Care	Not Covered	Not Covered

***There is a 12-month waiting period on the services in these policy benefit levels.**

Annual Maximum: The policy pays up to $1,200 per covered person. Unused annual maximums may not be carried over to future coverage years.

Deductible: There is a $50 deductible per Covered Person each Coverage Year. The deductible is the responsibility of the subscriber before the policy will pay out benefits. The deductible does not apply to Diagnostic and Preventive Services.

Coverage Year: Your coverage year is January 1 through December 31. A Coverage Year is a 12-month period in which deductibles and annual maximums apply. If you enroll after January 1, the coverage year for your first year will be from your effective date through December 31 and will begin again the following January 1.

DESCRIPTION OF COVERED SERVICES FOR ADULT MEMBERS

We cover the following dental care services for members who are over the age of 19 at the time the policy is issued or at the time policy renews.

Diagnostic and Preventive Services for adult members

Oral Evaluations:	Any type of evaluation (check-up or exam) is covered 2 times per calendar year. • Re-evaluations are not covered
Radiographs (X-rays):	• Bitewings- Covered 1 time every 2 calendar years.

	• Full Mouth (Complete Series) or Panoramic- Covered 1 time per 60-month period. • Periapical- 4 single x-rays every 12 months are covered • Occlusal – 2 series every 24 months are covered
Dental Cleanings (Prophylaxis), including Periodontal Maintenance and Full Mouth Scaling after an oral evaluation):	Covered 2 times per calendar year.

Basic Services for adult members

Amalgam Restoration (silver fillings):	Covered 1 time per tooth surface every 24 months.
Composite Resin Restorations (white fillings):	• Covered 1 time per tooth surface every 24 months. • Posterior (back) Teeth: Benefits will be limited to those of an amalgam (silver filling). The Covered Person will be responsible for the difference in cost between what the policy allows for silver fillings, and what is charged for more costly fillings, plus the deductible and coinsurance.
Resin-Based Composite Resin Crown, Anterior:	Covered 1 time per tooth surface every 24 months.
Resin-Based Composite Resin Crown, Posterior:	• Covered 1 time per tooth surface every 24 months. • Benefits will be limited to those of an amalgam (silver filling). The Covered Person will be responsible for the difference in cost between what the policy allows for silver fillings, and what is charged for more costly fillings, plus the deductible and coinsurance.
Recement Inlay, Onlay and Crowns:	Covered 6 months after initial placement.
Other covered basic services	• Emergency Treatment • Pulp Vitality tests

Endodontics for adult members

Pulpal Therapy on Primary Teeth	Covered 1 time per tooth per lifetime.
Therapeutic Pulpotomy	Covered 1 time per tooth per lifetime.
Endodontic retreatments	Covered 1 time per tooth per lifetime.
Root canal therapy	Covered 1 time per tooth per lifetime.
Other covered endodontic services:	• Partial Pulpotomy for apexogenesis • Bone graft with periradicular surgery

Periodontics for adult members

Full mouth debridement:	Covered 1 time per lifetime.
Periodontal scaling & root planning:	Covered 1 time per quadrant per 36 months.
Complex Surgical Periodontal Services:	• Gingival 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- Covered on natural teeth only LIMITATION: Only 1 complex periodontal service is covered per 36-month period per single permanent tooth or multiple teeth in the same quadrant.

Oral Surgery for adult members

Basic Extractions:	• Removal of coronal remnants on primary teeth • Extraction of erupted tooth or exposed root
Complex Surgical Extractions:	• Surgical removal of erupted tooth • Surgical removal of impacted tooth • Surgical removal of residual tooth roots • Coronectomy
Other Complex Surgical Procedures:	• Alveoloplasty • Vestibuloplasty • Surgical reduction of osseous tuberosity • Suture of recent small wounds up to 5 cm • Complicated suturing
General Anesthesia, Intravenous Conscious Sedation and IV Sedation:	Covered only when performed in conjunction with complex surgical service.

Major Restorative Services for adult members – after a 12-month waiting period

Gold Foil Restorations:	• Covered 1 time per tooth surface every 24 months. • Benefits will be limited to those of an amalgam (silver filling). The Covered Person will be responsible for the difference in cost between what the policy allows for silver fillings, and what is charged for more costly fillings, plus the deductible and coinsurance.
Inlays:	Benefits will be limited to those of an amalgam (silver filling). The Covered Person will be responsible for the

	difference in cost between what the policy allows for silver fillings, and what is charged for more costly fillings, plus the deductible and coinsurance.
Onlays and/or Permanent Crowns:	Covered 1 time per 5-year period per permanent tooth.
Crown, inlay, only, and veneer repair services	Covered 1 time per 12- month period.
Pre-fabricated or Stainless-Steel Crown:	Covered 1 time per 60-month period.
Other covered major restorative services:	• Other procedures to construct a new crown under existing denture framework

Prosthodontics for adult members – after a 12-month waiting period

Removable Prosthetic Services (Dentures and Partials):	Covered 1 time per 5-year period: • If 5 years have elapsed since the last covered removable prosthetic appliance, replacements will be covered only if the existing appliance cannot be repaired or adjusted.
Fixed Prosthetic Services (Bridge)	Covered 1 time per 5-year period: • If no more than 3 teeth are missing in the same arch; • If none of the individual units of the bridge has been covered previously as a crown or a cast restoration in the last 5 years; • If 5 years have elapsed since the last covered bridge, replacements will be covered only if the existing bridge cannot be repaired or adjusted.
Replacement of Broken Artificial Teeth:	• Covered 1 time per 6-month period, • When the prosthetic appliance is the permanent prosthetic appliance; and • Only after 6 months following initial placement of the prosthetic appliance; and • When the submitted narrative from the treating dentistsupports the procedure.
Reline and Rebase:	Covered 1 time per 24-month period: • When the prosthetic appliance is the permanent prosthetic appliance; and • Only after 6 months following initial placement of the prosthetic appliance
Other covered prosthodontic services	• Denture Adjustments • Partial and Bridge Adjustments • Recement Fixed Prosthetic

Implant Services for adult members – after a 12-month waiting period

Single Tooth Implant Body, Abutment and Crown:	Covered 1 time per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown. • Some adjunctive implant services may not be covered. It is recommended that a pre-treatment estimate be requested to estimate the amount of payment prior to beginning treatment.

TEMPOROMANDIBULAR JOINT DISORDER (TMD)

Dental treatment that is considered surgical or non-surgical treatment of temporomandibular joint disorder (TMD) and craniomandibular disorder, including splints, is covered as required by Minnesota Statutes Section 62A.043 Subd. 3. A Pre-treatment Estimate of Benefits is recommended for such treatment.

Dental services for TMD will be covered under this dental Plan within the applicable Plan limitations, maximums, deductibles and payment percentages of treatment costs.

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

RECONSTRUCTIVE DENTAL SURGERY

Benefits shall be provided for reconstructive dental surgery when such dental procedures are (i) incidental to or follow surgery resulting from injury, illness or other diseases of the involved part, or (ii) 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. Such coverage is provided within the applicable Plan limitations, maximums, deductibles and payment percentages and to the extent required by Minnesota Statute 62A.25.

CLEFT LIP AND CLEFT PALATE

Inpatient or outpatient dental expenses arising from dental treatment up to age 19, 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. Benefits for individuals age 19 up to the limiting age for coverage of the dependent are limited to inpatient or outpatient expenses arising from dental treatment that was scheduled or initiated prior to the dependent turning age 19.

GENERAL EXCLUSIONS FOR ADULT MEMBERS

In addition to specific limitations and exclusions listed in other sections of Summary of Dental Benefits, coverage is NOT provided for:

1) Dental services or health care services are not specifically stated as covered under the policy (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).
2) New, experimental, or investigational dental techniques or services may be denied until there is, to the satisfaction of Delta Dental, an established scientific basis for recommendation.
3) 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 you are responsible for the full charge.
4) Dental services completed prior to the date the covered person became eligible for coverage.
5) Dental services performed other than by a licensed dentist, licensed physician, or his or her employees.
6) Services performed by an anesthesiologist.
7) IV sedation and intravenous conscious sedation when services are performed with non-surgical dental care.
8) Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for surgical or non-surgical dental care, regardless of method of administration.
9) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital or other outpatient facility, unless specifically stated as covered.
10) Incomplete, interim, or temporary services.
11) Patient Assessment and screenings.
12) Nutritional counseling, tobacco counseling, and oral hygiene instructions.
13) Application of caries arresting medicaments.
14) Extraoral Radiographic Images, Sialography, or Interpretation of Diagnostic Images.
15) Space Maintainers and associated services.
16) Fluoride Treatments and Sealants.
17) Resin Infiltration of incipient smooth surface lesions.
18) Protective Restoration or Coping.
19) Restorative cast post/core or core build-up, including pins and posts.
20) Pin retention.
21) Veneers
22) Removal of pulpal debridement, pulp cap, post, pin(s), resorbable filling materials(s) and the procedures used to prepare and place the material(s) in the canals.
23) Apicoectomy or Periradicular Services, except those listed specifically as covered above.
24) Apexification or Recalcification Services, Pulpal Regenertion or Hemisection.
25) Treatment of root canal obstruction – non-surgical or internal root repairs.
26) Retrograde filling, Root amputation, or Intentional re-implantation.

27) Gingivectomy/ gingivoplasty, Anatomical crown exposure, Apically positioned flap, crown lengthening, or guided tissue regeneration.
28) Occlusal procedures, including occlusal guards and adjustments.
29) Surgical exposure of impacted or unerupted tooth for orthodontic reasons.
30) Any other oral surgery procedures that are not specifically listed as covered above.
31) Canal prep & fitting of preformed dowel & post.
32) Prosthodontic or Implant services to replace teeth that were missing prior to the effective date of this policy. This exclusion will no longer apply once a covered person has been covered under this policy for 24 consecutive months.
33) 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.
34) Artificial material implanted or grafted into or onto bone or soft tissue, including implant services and associated fixtures, or surgical removal of implants, except as stated as covered in the sections above.
35) Services or supplies that have the primary purpose of improving the appearance of teeth. This includes, but is not limited to, bleaching, tooth whitening agents or tooth bonding and veneer covering of the teeth.
36) Case presentations, consultations, and office visits.
37) Athletic mouth guards, enamel microabrasion and odontoplasty.
38) Bacteriologic tests.
39) Cytology sample collection.
40) Separate services billed when they are an inherent component of a dental service where the benefit is reimbursed at the Maximum Allowable Fee.
41) Interim or temporary removable or fixed prosthetic appliances (dentures, partials, or bridges).
42) Additional, elective or enhanced prosthetic procedures including but not limited to, connector bar(s), stress breakers, and precision attachments.
43) Provisional splinting, temporary procedures or interim stabilization.
44) Placement or removal of sedative filling, base or liner used under a restoration.
45) Occlusal procedures.
46) Adjunctive diagnostic tests.
47) Cone beam images.
48) Sinus augmentation.
49) Brush biopsy and the accession of a brush biopsy.
50) Restorations placed for cosmetic purposes.
51) Inlays, onlays, and crowns place for cosmetic purposes.
52) 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.
53) Orthodontic treatment services

Coordination of Benefits with Worker's Compensation, Federal Medicare, and Federal Veteran's Administration programs:

Delta Dental will not be responsible for services that a covered person is entitled to receive for little to no out of pocket expense due to coverage under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. Delta Dental will coordinate benefits with any government program when a covered person is left with an out of pocket responsibility. Any claims paid through this Coordination of Benefits provision will be processed according to the coverages outlined in the policy.

POST-PAYMENT REVIEW

As part of Delta Dental's claim payment approval process, Delta Dental is 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, information and records related to a covered person as may be required to pay claims. Also, Delta Dental may require that a covered person be examined by a dental consultant retained by Delta Dental in or near the covered person's place of residence. Delta Dental shall hold such information and records confidential.

Dental services are evaluated after treatment is rendered for accuracy of payment, benefit coverage and potential fraud and 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 pre-treatment estimate was submitted for the service.

ELIGIBILITY

Subscriber- To be a subscriber, the applicant must meet the following requirements:

a) Be determined by the Exchange to be a Qualified Individual or enrollment in a Qualified Dental Plan (QDP);
b) Be a United States citizen or national; or
c) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
d) Be a Minnesota resident;
e) Agree to pay for the cost of premium that Delta Dental requires;
f) Not be incarcerated (except pending disposition of charges);
g) Not be covered by any other group or individual dental plan.

For a Qualified Individual age 19 and over, the applicant must:

- Not be living in an institution;
- Be capable of indicating intent;
- Not be receiving optional State supplementary payments (SSP); and
- Reside in the Service Area of the Exchange.

For a Qualified Individual under age 19, the applicant must:

- Not be living in an institution;
- Not be eligible for Medicaid based on the receipt of federal payments for foster care and adoption assistance under Social Security;
- Not be emancipated;
- Not be receiving optional State supplementary payments (SSP); and reside in the Service Area of the Exchange.

For purposes of Eligibility, a Qualified Individual's service area is the area in which the Qualified Individual:

1) Resides, intends to reside (including without a fixed address); or
2) Is seeking employment (whether or not currently employed); or
3) Has entered without a job commitment.

For Qualified Individuals under age 19 who purchase the Essential Health Benefit, the service area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with Members in multiple Exchange Service Areas:

1) All of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Dental Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2) If both spouses in a tax household enroll in a Qualified Dental Plan through the same Exchange, a tax Dependent may only enroll in a Qualified Dental Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets a residency standard.

Dependents- To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment completed by the Subscriber, except as covered in this policy, be determined by the Exchange to be a Qualified Individual and meet all Dependent eligibility criteria. The following Dependents of a policyholder may be covered under this policy:

1) Spouse, meaning:
    a. Married
    b. Qualified domestic partner, if all of the following criterial are met:
        i. Are not related by blood closer than permitted under applicable state marriage laws;
        ii. Are not married and do not have any other domestic partners;
        iii. Are at least 18 years of age and have the capacity to enter in a contract;
        iv. Share a residence;

    All references to spouses in this policy will include domestic partners.

2) Dependent children up to the age of 26, including:
    a. You and your spouse's natural-born, legally adopted children, and children placed for adoption;
    b. Children for whom you and your spouse are the legal guardian;

c. 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 Delta Dental
d. Stepchildren; and
e. Grandchildren who are financially dependent on you and reside with you or your covered spouse continuously from birth.

3) Disabled children age 26 or older if:
   a. They are primarily dependent upon you and your spouse;
   b. They are incapable of self-sustaining employment by reason of development disability, mental illness or disorder, or physical disability; and
   c. Were disabled before they reached age 26.

4) Siblings, including half-siblings and step-siblings, to the Subscriber, if the Subscriber is under age 19.

The Exchange may require the Subscriber to submit proof of continued eligibility for any enrolled child not including disabled children. Your failure to provide this information could result in termination of a child's coverage. In the event of divorce or legal separation, coverage for a former spouse and/or dependent children will continue until the date of any of events noted in section TERMINATION OF COVERAGE below; or the date the former spouse becomes covered under any group health plan, whichever occurs earlier.

EFFECTIVE DATES OF COVERAGE

Your policy begins on the effective date, which is the first day of the following Benefit Year for the Qualified Individual who has made a QDP selection during the annual open enrollment period. The effective date will be determined by MNsure and provided to Delta Dental.

Effective dates for special enrollment period:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. Advance payments of the premium tax credit are not effective until the first day of the following month in which you provided notice, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2) In the case of marriage, or in the case where a Qualified Individual loses his or her Minimum Essential Coverage, coverage is effective on the first day of the following month in which you have provided notice.

OPEN ENROLLMENT

As established by the rules of the MNsure Exchange, Qualified Individuals are only permitted to enroll in a Qualified Dental Plan (QDP), or as an enrollee to change QDPs, during the annual

open enrollment period or a special enrollment period for which the Qualified Individual has experienced a qualifying event.
An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QDP, and enrollees may change QDPs at that time according to rules established by MNsure.
American Indians are authorized to move from one QDP to another QDP once per month.

CHANGES AFFECTING ELIGIBILITY AND SPECIAL ENROLLMENT

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QDP through MNsure, outside of the annual open enrollment period.

If a dependent is no longer eligible under the current policy due to a triggering event, they have the right to continue coverage as a new insured and to obtain a policy in their own name.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QDP.

MNsure must allow Qualified Individuals and enrollees to enroll in or change from one QDP to another as a result of the following triggering events:

- A Qualified Individual or dependent loses his or her Minimum Essential Coverage. The term Minimum Essential Coverage means any of the following: Government-sponsored programs; coverage under an eligible employer-sponsored plan coverage under a health plan offered in the individual market within a state; coverage under a grandfathered health plan; and such other health benefits coverage such as a state health benefits risk pool, or as the Secretary of HHS recognizes);
- A Qualified Individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;
- A Qualified Individual loses his or her coverage due to death of the original policy holder;
- A Qualified Individual loses his or her coverage due to no longer qualifying as a dependent due to age on the original policy;
- An individual, not previously a citizen national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QDP is unintentional, inadvertent, or erroneous and is the result of an error of MNsure or the Department of Health and Human Services (HHS), or its instrumentalities are determined by MNsure. In such cases, MNsure may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to MNsure that the QDP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for Cost-Sharing reductions, regardless of whether such individual is already enrolled in a QDP;
- MNsure must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QDPs as a result of a permanent move; and
- A Qualified Individual or enrollee demonstrates to MNsure, in accordance with HHS guidelines, that the individual meets other exceptional circumstances that MNsure may provide.

TERMINATION OF COVERAGE

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

a) The date determined by MNsure as a result of you requesting termination with appropriate notice to MNsure or the QDP;
b) The date you cease to be eligible;
c) For any covered dependents, the day your dependent ceases to be a dependent, as defined in the eligibility section of this booklet;
d) The last day of the month for which a premium has been paid, subject to the grace periods;
e) The date the policy ends; or
f) The date that Delta Dental ceases to offer all coverage in the individual and family market, as permitted by applicable law.

RENEWABILITY

This policy will continue as long as your premiums are paid, subject to the grace period, and you continue to be eligible as determined by MNsure.

We will only change the premiums or the benefits provided in this policy by providing you with a 31 days prior written notice.

CLAIM PROVISIONS

Notice of Claims: When a claim arises for services you have already received, you should notify us of the charges incurred in writing. This written notice of claim must be given within 20 days after any charges are incurred, or as soon as reasonably possible. Notice, including sufficient information to identify you and the service, given by you or on behalf of you, will be deemed notice and should be sent to:

Delta Dental of Minnesota
PO BOX 9120
Farmington Hills, MI 48333-9085

Claim Forms: After receiving your notice of claim, we will provide you the necessary claim forms for filling proofs of loss. If we do not give you these forms within 15 days after you have filed your notice of claim, you should submit written proof which documents the date and type of service, your care provider's name, and itemized charges for which the claim is being made.

Claim Payments: Payments are made by Delta Dental only when the covered dental procedures have been completed. In order to properly process a claim, Delta Dental may be required to add an administrative policy line to the claim. Duplicate claims previously processed will be denied.

When services are received from a participating provider, any benefits payable under this policy are paid directly to the provider. The subscriber is responsible for paying the provider directly for any remaining coinsurance, deductibles or non-covered services.

When services are received by a non-participating provider, any benefits payable under the policy are paid directly to the Subscriber. The Subscriber is responsible for paying the provider.

Time of Payment of Claim: We will make payment promptly upon receipt of written proof of loss. Benefits which are payable periodically during a period of continuing loss, for example orthodontic services, shall be payable at least on a quarterly basis. We will notify you of our benefit determination if you have any remaining liability within 30 days of receipt of a completed claim. This time period may be extended by us for an additional 15 days in case of circumstances beyond our control.

CLAIMS AND APPEAL PROCEDURES

Proof of Loss: All claims should be submitted within 12 months of the date of service. Claims will not be invalidated or reduced if it is 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 of receipt of your claim. You may receive a written notice of this benefit determination when there is money owed by the subscriber to the dentist. 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 30-day period. We will tell you the reason we require an extension and the date by which we expect to make a decision. If the extension is needed for us to receive 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 us with 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 submitted to us in writing 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
Attn: Professional Services Appeals and Grievances
PO Box 30416
Lansing, MI 48909

You may submit written comments, documents or other information that you feel supports your appeal. Upon request, you will also be given reasonable access to and copies of all relevant records that are 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 of the claim will not be given any weight.

The review will be done by a different person than the original decision-maker, 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 policy, claims are not reviewed to determine dental necessity or appropriateness, except in the case of pediatric orthodontic services. 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 on our Authorization to Release Information form. This form is available on our website or by calling Customer Service. You can revoke the authorized representative at any time.

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

External Review Process
Minnesota Department of Commerce
Main Office, Golden Rule Building
85 7th Place East, Suite 280
St. Paul, MN 55101

Website: https://mn.gov/commerce/about/contact/
Phone: local- 651-539-1500, Greater Minnesota only- 1-800-657-3602

Mail written complaints to:

Minnesota Department of Commerce
Attn: Consumer Protection & Education Division
85 7th Place East, Suite 280
St. Paul, MN 55101

Online Complaints: https://mn.gov/commerce/consumers/file-a-complaint/file-a-complaint

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.

DELTA DENTAL OF MINNESOTA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

Delta Dental of Minnesota is required by law to maintain the privacy of your Personal 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 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 the purpose of 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 use and disclose your PHI in order to process your claim.

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.

Unless you object, we may disclose your PHI to a family member, or 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 judgement to determine whether a disclosure of this type is in your best interest.

We may also use or disclose PHI without your authorization for several other reasons. Subject to certain requirements, we may use and 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 agencies to lessen a serious and imminent threat to the health or safety of you or the public. In 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 further 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 the most current notice is posted at deltadentalmn.org/about-us/hipaa-privacy-notice/.

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 Delta Dental. 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 or payment of 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 Delta Dental's 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:

Delta Dental of Minnesota
Attn: Customer Service
PO Box 1886
Indianapolis, IN 46206-1886

Or by phone: 855-643-3582

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 & HEALTH INSURANCE GUARANTY ASSOCIATION
3300 WELLS FARGO CENTER | 90 SOUTH 7TH STREET | MINNEAPOLIS, MN 55402
Phone: 612.322.8713 | Fax: 402.474.5393 | info@mnlifega.org

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 case 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 issues 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 case 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 require 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 assess 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

Customer Service
Delta Dental of Minnesota
P.O. Box 1886
Indianapolis, IN 46206-1886
(855) 643-3582

Claims Address
Delta Dental of Minnesota
P.O. Box 9120
Farmington Hills, MI 48333

Corporate Office
Delta Dental of Minnesota
500 Washington Avenue South, Suite 2060
Minneapolis, MN 55415-1163