Delta Dental of Minnesota

Delta Dental
Individual and Family
Adult Gold + Kids Plan

Dental Benefit Plan Summary

Delta Dental Individual and Family[SM]-
Adult Gold + 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. If any part of your application is wrong, please contact Delta Dental Customer Service. 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	DELTA DENTAL OF MINNESOTA
BY: Nadia C. Martyn	AND BY: Tamara K. Ryf
TITLE: Assistant Secretary	TITLE: President

TABLE OF CONTENTS

Delta Dental Individual and Family Policy

Delta Dental of Minnesota will pay the benefits described in this Policy subject to its provisions.

Delta Dental of Minnesota does not discriminate or restrict access to its dental policies on the basis of sex, including gender identity. Delta Dental of Minnesota assures that services that are ordinarily or exclusively available to individuals of one sex will not be denied to a transgender individual based on the sex assigned to that individual at birth.

This Policy is a legal contract between the Policy Owner and Delta Dental of Minnesota. This Policy is subject to the laws of the State of North Dakota.

PREMIUM CALCULATIONS AND 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 74008405
Chicago, IL 60674-8405

The payment of any premium will keep the coverage in force to the next premium due date, subject to the Grace Period provision of the Policy.

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

ENTIRE CONTRACT: This membership contract is your evidence of coverage, issued by Delta Dental of Minnesota. This contract, along with your enrollment form is the binding contract between you (the Subscriber) and Delta Dental. All statements made by you will be deemed representations and not warranties.

Because this is a contract, no one except an executive officer of Delta Dental has the authority to make or change this contract or to extend the time for payment of your premium. Changes to this contract will not be valid unless there is an endorsement or amendment signed by Delta Dental's President or a Senior Vice President and attached as an amendment to this contract. Any change that meets these requirements will be binding with you, the Subscriber, and for any other person(s) referred to in this policy.

GRACE PERIOD: A Grace Period of 90 days will be granted for the payment of premiums after the first premium. The coverage under this contract will continue in force during such Grace Period, but the Policyholder will be liable for the premium for any period such coverage continues in force, provided written notice of termination has not been previously given to Delta.

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.

CONFORMITY TO LAW: Any provision of this Contract, which on its Effective Date, is in conflict with the laws of the state in which the Contract was delivered or issued for delivery, is considered amended to conform to the applicable requirements of such state.

CLERICAL ERROR: Clerical error by the Policyholder will not invalidate insurance otherwise validly in force nor continue insurance otherwise terminated.

CONTRACT TERM: This Contract continues until December 31 each year, so long as the premium is paid, subject to the Grace Period.

TERMINATION OR CANCELATION OF POLICY: You may cancel this policy by giving Delta Dental written or verbal notice of your intent to cancel. When contacting Delta Dental, the notice must be submitted to the address or phone number as stated on the back of your ID card or found in this Policy. When notice is given, the cancelation date can be effective as soon as the first of the following month.

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.

REINSTATEMENT: If any renewal premium is not paid within the time granted to you for payment, a subsequent acceptance of premium by Delta Dental or by any agent duly authorized by Delta Dental to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy.

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

SUMMARY OF DENTAL BENEFITS PROVISIONS MADE PART OF THE CONTRACT

The remainder of this policy consists of provisions shown in the Summary of Dental Plan Benefits as issued to the Subscriber. Amendments, if any, adding or changing the provisions of the Summary are also made part of this Contract.

Notice of Non-Discrimination and Accessibility Requirements
Delta Dental of Minnesota and its affiliates, collectively referred to herein as "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 (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)).

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, other 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 number on the back of your ID card

If you believe that 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 Delta Dental of Minnesota, Attn: Complaints, Appeals, and Grievances, 500 Washington Ave South, Suite 2060 Minneapolis, MN, 55415, 612-224-3300 or 877- 268-3384, fax:612-351-5104. You can 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 can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Notifications

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1- 800-448-3815. (Spanish)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800- 448-3815. (Hmong)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-448-3815. (Cushite)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-448- 3815. (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 1-800-448-3815. (Chinese)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-448-3815. (Russian)

ໂປດຊາບ: ຖ້ າວ່ າ ທ່ ານເວ ົ້ າພາສາ ລາວ, ການບໍ ລິ ການຊ ່ ວຍເຫ ຼ ືອດ ້ ານພາສາ, ໂດຍບ ່ ສ ັ ເສ ຽ ຄ ່ າ, ແມ ່ ນມ ີ ພ ້ ອມໃຫ ້ ທ ່

ໆນ. ໂທຣ 1-800-448-3815. (Laotian)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800- 448-3815. (Amharic)

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ. နမၤနှ့ ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1-800-448-3815. (TTY: 711). (Karen)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-448-3815. (German)

ملحوظة: إذا كنت تتحدث اذكر لغتك، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-448-3815 (رقم.) (Arabic)

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-448-3815. (French)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-448-3815.번으로 전화해 주십시오. (Korean)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-448-3815. (Tagalog)

ئاگاداری (Kurdish) 800 -1 بکە. .هەتسەدرەب-448-3815. بە پ

توجه: اگر به زبان فارسی گفتگو می دینک، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. تماس با 1-800-553-9536 (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。1-800-448- 3815.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 1-800-448-3815. (Bantu)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-448-3815. (Swahili)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-800-448-3815. (Norwegian)

សូមប្រុងប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយ [ភាសាខ្មែរ], សេវាជំនួយភាសាដោយឥតគិតថ្លៃ, ដែលអ្នកអាចប្រើប្រាស់បាន។ សូមហៅទូរស័ព្ទ 1-800-448-3815. (Cambodian/Khmer)

SUMMARY OF DENTAL PLAN BENEFITS

Essential Health Benefits - Pediatric Dental (Must be18 years old or younger)

The Annual Out-of-Pocket Maximum includes amounts that you have paid for covered services, such as deductible and coinsurance amounts. It does not include premiums payments made or payment for services not covered by the policy.

Annual Out-of-Pocket Maximum for covered services for Participating Dentists	$400 per covered child/ $800 per covered children in family
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

Service Type	Participating Dentist	Non-participating Dentist
Diagnostic and Preventive Services*	100%	100%
Basic Services	50%	50%
Endodontics/Periodontics/Oral Surgery	50%	50%
Major Restorative Services	50%	50%
Prosthodontics/Eligible Implant Services	50%	50%
Dentally Necessary Orthodontic Care	50%	50%

* The Deductible does not apply to Diagnostic and Preventive Services

Adult Dental Benefits – Non-Essential Health Benefits (Must be 19 years old or older)

Delta Dental Gold

Annual Maximum (per member) $1,000

Annual Deductible (per member) $50

The Deductible does not apply to Diagnostic and Preventive Services.

Service Type	Participating Dentist	Nonparticipating Dentist
Diagnostic and Preventive Service	100%	100%
Basic Services	50%	50%
Endodontics/Periodontics/Oral Surgery	50%	50%
Major Restorative Services*	25%	25%
Prosthodontic Repairs and Adjustments*	25%	25%
Prosthodontics*	25%	25%

*A 12-month waiting period must be satisfied before benefits can be received

Benefit Maximums

Adult Dental Benefits – Non-Essential Health Benefits:

The Policy pays up to a maximum of $1,000.00 for each Covered Person per Coverage Year subject to the fee schedule amounts and the coverage percentages identified within the Summary of Dental Benefits. Unused Benefit Maximums may not be carried over to future coverage years.

Deductible

Pediatric Dental Benefits – Essential Health Benefits: There is a $50 deductible per Covered Person each Coverage Year. The deductible does not apply to any Diagnostic and Preventive Services within the Essential Health Benefits.

Adult Dental Benefits - Non-Essential Health Benefits:
There is a $50 deductible per Covered Adult each Coverage Year. The deductible will 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 benefit 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 PROCEDURES

Pretreatment Estimate
(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 statement will also outline amounts you will have to pay to the dentist, such as coinsurance, deductibles, and non-covered services.
- 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.

Dental Necessity

Delta Dental performs dental necessity reviews to determine whether a service submitted for payment or benefit under this Plan is a dental procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. Dental services may be subject to pre-payment clinical review of dental records. It is Delta Dental's policy that a licensed dentist reviews claims where a dental necessity determination is made, and denies the oral health service where dental necessity has not been demonstrated. Denials based solely on coverage specifications, limitations, and exclusions under the enrollee's contract are not considered utilization review and not evaluated for dental necessity.

Delta Dental evaluates dental procedures submitted to determine if the procedure is a covered benefit under your dental plan. Your dental Plan includes a preset schedule of dental services that are eligible for benefit by the Plan. Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this plan. While these services may be necessary for your dental condition, they may not be covered by us. You are responsible for any costs that are not covered by the Plan or exceed the frequency of the Plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for dental services that are not covered or benefited by the Plan. The decision as to what dental care treatment is best for you is solely between you and your dentist.

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.

Benefits

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

As a condition precedent to the approval of claim payments, Delta Dental shall be entitled to request and receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which a dentist's care is provided, such information and records relating to a Covered Person as may be required to pay claims. Also, 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.

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

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 covered 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.

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

Description of Covered Services for Pediatric Members – Essential Health Benefits

We cover the following dental care services for members through the year in which the insured turns 19 years of age when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally

acceptable treatment for your dental condition, we will cover the least expensive.

Diagnostic & Preventive Services for Pediatric Members

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

Radiographs (X- rays)

- **Bitewings** - Covered at 1 series of bitewings per calendar year.
- **Full Mouth (Complete Series) –** Covered 1 time per 36-month period.
- **Panoramic** – covered 1 time per 36-month period.
- **Periapical(s)**
- **Occlusal** – Covered at 2 series per 24-month period.

Dental Cleaning (Prophylaxis) – Any combination of this procedure, Periodontal Maintenance and Full Mouth Scaling after an oral evaluation are covered 4 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 or Preventive Resin Restorations - Any combination of these procedures is covered 2 times per lifetime for permanent first and second molars and bicuspids.

Space Maintainers and Recement Space Maintainer

Basic Services for Pediatric Members

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

Amalgam (silver) Restoration. Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.

Composite (white) Resin Restorations. Treatment to restore decayed or fractured permanent or primary teeth.

Pin Retention – Limited to 2 occurrences per lifetime.

General Anesthesia, Intravenous Conscious Sedation and IV Sedation – Covered when performed in conjunction with complex surgical service.

> LIMITATION: General anesthesia, intravenous conscious sedation and IV sedation will not be covered when performed with non-surgical dental care.

Endodontics for Pediatric Members

Endodontic Therapy on Primary Teeth

- **Pulpal Therapy**- Limited to 1 time per lifetime.
- **Therapeutic Pulpotomy** –Limited to 1 time per lifetime.

Endodontic Therapy on Permanent Teeth

- **Root Canal Therapy**

Other Endodontic

Treatments

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation
- Hemisection
- Retrograde filling
- Pulp capping
- Treatment of Root canal obstruction
- Internal Repair of Perforation Defects
- Bleaching of endodontically treated anterior teeth

Periodontics for Pediatric Members

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

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

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

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

Crown Lengthening – Covered once per lifetime.

Occlusal Guard – Covered 1 time every 3 years.

Oral Surgery for Pediatric members

Basic Extractions

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

Complex Surgical Extractions

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

Other Complex Surgical Procedures

- Alveoloplasty

Other Oral Surgery Procedures.

- Incision and drainage of cyst or abscess (intraoral soft tissue)
- Excision or pericoronal gingival
- Coronectomy
- Suture of recent small wounds up to 5 cm
- Frenulectomy
- Osseous graft

Major Restorative Services for Pediatric Members

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

Inlays – Covered 1 time per 5-year period. Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances**.** The patient must pay the difference in cost between Delta Dental's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

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

Pre-fabricated or Stainless Steel Crown - Covered 1 time per 60-month period.

Recement Inlay, Onlay and Crowns – Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair – Covered 1 time per 12-month period per tooth 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.

Veneers – Veneers performed for non-cosmetic reasons are covered 1 time per 5-year period.

Prosthodontics for Pediatric Members

Tissue conditioning

Reline and Rebase – Covered 1 per 36-month period;

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

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) – Covered 1 per 12-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance(denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments – Covered 2 times per 12-month period:

- when the denture is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the denture.

Partial and Bridge Adjustments – Covered 2 times per 24-month period:

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

Removable Prosthetic Services (Dentures and Partials) – Covered 1 time per 5-year period;

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

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

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have elapsed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

LIMITATION: If there are multiple missing teeth, a removable partial denture may be the benefit since it would be the least costly, commonly performed course of treatment. The optional benefit is subject to all contract limitations on the covered service.

Recement Fixed Prosthetic - covered 1 time per 12-month period.

Relining of Immediate Dentures – covered 1 time during the year after insertion of the immediate dentures.

ORTHODONTIC CARE

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 should submit your 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 met:

a) Dentition affected by significant clef lip/palate, craniofacial or developmental disorder
b) Deep impinging overbite with either palatal trauma or mandibular anterior gingival trauma
c) Crossbite of individual anterior teeth with evidence of clinical attachment loss and/or recession of the gingival margin
d) Severe traumatic deviation
e) Severe anterior-posterior occlusal discrepancy with an overjet equal to or greater than 9 m or reverse overjet equal or greater than 3.5mm
f) Impacted permanent anterior teeth which are contributing to a handicapping malocclusion
g) Extensive hypodontia (excluding third molars)
h) A score greater than 20 on the malocclusion index as defined by the North Dakota Department of Human Services (January 2018) using the "Health Tracks Comprehensive Orthodontic Screening" document.

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 are made over the course of your treatment. The Covered Person must continue to be eligible under Delta Dental in order to receive ongoing payments for your orthodontic treatment.

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

Limitations Applicable to Pediatric Members – Essential Health Benefits
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.

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. 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 Applicable to Pediatric Members – Essential Health Benefits
In addition to specific exclusions set forth in other sections of this Dental Benefit Plan Summary, coverage is NOT provided for:

a) Dental services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare Policy, or Federal Veteran's Administration Policy. However, if a Covered Person receives a bill or direct charge for dental services under any governmental Policy, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a Policyholder or Dependent who is eligible for or receiving Medical Assistance.

b) Dental services or health care services not specifically covered under the Dental Plan Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).

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.

c) Dental services performed for cosmetic purposes. NOTE: Dental services are subject to post-payment review of dental records. If services are found to be cosmetic, we reserve the right to collect any payment and the member is responsible for the full charge.

d) Dental services completed prior to the date the Covered Person became eligible for coverage.

e) Services of anesthesiologists.

f) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.

g) Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

h) Dental services performed other than by a licensed dentist, licensed physician, his or her employees.

i) 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.

j) Artificial material implanted or grafted into or onto bone or soft tissue, including implant services and associated fixtures, or surgical removal of implants.

k) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to, bleaching, tooth whitening agents or tooth bonding and veneer covering of the teeth.

l) Case presentations, office visits and consultations.

m) Extra-oral x-rays.

n) Interpretation of diagnostic images.

o) Incomplete, interim or temporary services.

p) Athletic mouth guards, enamel microabrasion and odontoplasty.

q) Procedures designed to enable prosthetic or restorative services to be performed.

r) Bacteriologic tests.

s) Cytology sample collection.

t) Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.

u) Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).

v) Services for the replacement of an existing partial denture with a bridge.

w) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.

x) Provisional splinting, temporary procedures or interim stabilization.

y) Placement or removal of sedative filling, base or liner used under a restoration.

aa) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.

bb) Oral hygiene instruction.

cc) Restorative cast post/core or core build-up, including pins and posts.

dd) Occlusal procedures, except as stated as covered above.

ee) Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.

ff) Implant maintenance, repair to an implant, or implant abutment.

gg) Pulp vitality tests

hh) Resin infiltration/Smooth surface.

ii) Adjunctive diagnostic tests.

jj) Diagnostic casts.

kk) Cone beam images.

ll) Anatomical crown exposure.

mm) Temporary anchorage devices.

nn) Sinus augmentation.

oo) Brush biopsy and the accession of a brush biopsy.

pp) Vestibuloplasty, removal of exostosis, surgical reduction of osseous tuberosity, tooth re-implantation of accidentally displaced tooth, or treatment of fractures or dislocations.

qq) Restorations placed for preventive or cosmetic purposes.

rr) Inlays, onlays and crowns placed for preventive or cosmetic purposes.

ss) 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.

Description of Covered Services for Adult Members – Non-Essential Health Benefits

We cover the following dental care services for members age 19 and older when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, we will cover the least expensive.

Waiting Periods

New Policyholders and their Eligible Dependents will be subject to a 12-month waiting period for Major Restorative and Prosthodontics.

Diagnostic & Preventive Services for Adult Members

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

Radiographs (X-rays)

- **Bitewings** - Covered at 1 series of bitewings every 2 calendar years.
- **Full Mouth (Complete Series) or Panoramic –** Covered 1time per 60-month period.
- **Periapical(s)** – 4 single X-rays are covered per 12-month period.

- **Occlusal** – Covered at 2 series per 24-monthperiod.

Prophylaxis or Periodontal Maintenance - Any combination of this procedure, Periodontal Maintenance and Full Mouth Scaling after an oral evaluation are covered 2 times per calendar year.

Basic Services for Adult Members

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

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

Composite (white) Resin Restorations

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

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

General Anesthesia, Intravenous Conscious Sedation and IV Sedation – Covered when performed in conjunction with complex surgical service.

Pulp Vitality tests.

Diagnostic Casts.

Endodontics for Adult Members

- Pulpal Therapy – Covered 1 time per tooth, per lifetime.
- Root Canal Therapy – Covered 1 time per tooth, per lifetime.
- Endodontic Retreatments – Covered 1 time per tooth per lifetime.

Periodontics for Adult Members

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

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

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

- **Gingivectomy/gingivoplasty**
- **Gingival flap**
- **Apically positioned flap**

- **Osseous surgery**
- **Bone replacement graft**
- **Pedicle soft tissue graft**
- **Free soft tissue graft**
- **Subepithelial connective tissue graft**
- **Soft tissue allograft**
- **Combined connective tissue and double pedicle graft**
- **Distal/proximal wedge**

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

Oral Surgery for Adult Members

Basic Extractions

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

Complex Surgical Extractions

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

Other Complex Surgical Procedures

- Alveoloplasty
- Tooth re-implantation of accidentally displaced tooth
- Surgical repositioning of teeth
- Incision and drainage of abscess
- Suture of recent small wounds up to 5cm
- Excision of hyperplastic tissue
- Excision of pericoronal gingiva

Major Restorative Services for Adult Members* 12 month waiting period applies to these benefits

Gold foil restorations - Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances. The patient must pay the difference in cost between Delta Dental's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit. Covered 1 time per 24-month period.

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

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

treatment, plus any coinsurance for the covered benefit.

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

Pre-fabricated or stainless steel crowns – Covered 1 time per 5 year-year period per tooth.

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

Prosthodontics for Adult Members* 12 month waiting period applies to these benefits

Reline and Rebase - Covered 1 per 24-month period:

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

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) - Covered 1 per 6-month period:

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

Denture Adjustments - Covered 2 times per 12-month period:

- when the denture is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the denture.

Partial and Bridge Adjustments - Covered 2 times per 24-month period:

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

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

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

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

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

Implant Supported Fixed and Removable Prosthetic (Crowns, Bridges, Partials and Dentures) - A restoration that is retained, supported and stabilized by an implant.

LIMITATION: This procedure receives an optional treatment benefit equal to the least expensive professionally acceptable treatment. The additional fee is the patient's responsibility. For example, a single crown to restore one open space will be given the benefit of a Fixed Partial Denture Pontic (one unit). The optional benefit is subject to all contract limitations on the benefited service.

General Exclusions Applicable to Adult Members – Non-Essential Health Benefits
In addition to specific exclusions set forth in other sections of this Dental Benefit Plan Summary, coverage is NOT provided for:

a) Dental services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare Policy, or Federal Veteran's Administration Policy. However, if a Covered Person receives a bill or direct charge for dental services under any governmental Policy, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a Policyholder or Dependent who is eligible for or receiving Medical Assistance.

b) Dental services or health care services not specifically covered under the Dental Plan Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).

c) New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of Delta Dental, an established scientific basis for recommendation.

d) Dental services performed for cosmetic purposes. NOTE: Dental services are subject to post-payment review of dental records. If services are found to be cosmetic, we reserve the right to collect any payment and the member is responsible for the full charge.

e) Dental services completed prior to the date the Covered Person became eligible for coverage.

f) Services of anesthesiologists.

g) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.

h) Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

i) Dental services performed other than by a licensed dentist, licensed physician, his or her employees.

j) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

k) Artificial material implanted or grafted into or onto bone or soft tissue, including implant services and associated fixtures, or surgical removal of implants.

l) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.

m) Orthodontic treatment services.

n) Case presentations, office visits and consultations.

o) Sealants, space maintainers, and fluoride.

p) Incomplete, interim or temporary services.

q) Corrections of congenital conditions during the first 24 months of continuous coverage under this Plan.

r) Athletic mouth guards, enamel microabrasion and odontoplasty.

s) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under Delta Dental.

t) Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.

u) Bacteriologic tests.

v) Cytology sample collection.

w) Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.

x) Services for the replacement of an existing partial denture with a bridge.

y) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.

z) Provisional splinting, temporary procedures or interim stabilization.

aa) Placement or removal of sedative filling, base or liner used under a restoration.

bb) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.

cc) Oral hygiene instruction.

dd) Restorative cast post/core or core build-up, including pins and posts.

ee) Occlusal procedures.

ff) Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.

gg) Implant maintenance or repair to an implant or implant abutment.

hh) Adjunctive diagnostic tests.

ii) Incomplete root canals.

jj) Cone beam images.

kk) Anatomical crown exposure. ll)

Temporary anchorage devices.

mm) Sinus augmentation.

nn) Brush biopsy and the accession of a brush biopsy.

oo) Restorations placed for preventive or cosmetic purposes.

pp) Inlays, onlays and crowns placed for preventive or cosmetic purposes.

qq) 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.

rr) Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).

ss) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.

tt) Intentional reimplantation.

uu) Apicoectomy.

vv) Root Amputation.

ww) Apexification.

xx) Retrograde filling.

yy) Coverage for Temporomandibular Joint Disorder (TMD) related services.

zz) Hemisection

aaa) Canal prep & fitting of preformed dowel &post.

bbb) Placement or removal of sedative filling, base, or liner used under a restoration.

ccc) Initial installation of full or partial dentures, implants or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a Covered Person under this Plan. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this Plan for more than 24 months.

ddd) Coverage for congenitally missing teeth. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this dental benefit plan for more than 24 months.

Post Payment Review

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

ELIGIBILITY

Covered Persons under this Policy are:

Subscriber

a) All Subscribers who have met the eligibility requirements as established and stated within this Dental Benefit Plan Summary under Effective Date of Coverage; and

b) Is a North Dakota resident.

Dependents, if Dependent coverage is elected

A. Spouse, meaning:

1. Married;
2. Legally separated;

3. Qualified domestic partner of a Policyholder, if all of the following criteria are met:
    a. are not related by blood closer than permitted under applicable marriage laws;
    b. are not married and do not have any other domestic partners;
    c. are at least eighteen (18) years of age and have the capacity to enter into a contract;
    d. share a residence;
    e. are jointly responsible to each other for the necessities of life and, if asked, could produce documentation of at least three of the following items as evidence of joint responsibility:
        - joint mortgage or joint tenancy on a residential lease;
        - joint bank account;
        - joint liabilities (e.g., credit cards or car loans);
        - joint ownership of significant property (e.g., cars, land, etc.);
        - naming of each other a primary beneficiary in wills or life insurance policies;
        - written notarized agreements or contracts regarding the relationship, showing mutual support obligations, or joint ownership of assets acquired during the relationship;
        - commitment to a long-term relationship with the intention of remaining together indefinitely.

B. Dependent children until the end of the year in which a child turns 26 years of age, including:
    1. Natural-born and legally adopted children (including children placed with you for legal adoption. NOTE: A child's placement for adoption terminates upon the termination of the legal obligation of total or partial support.
    2. Children of the domestic partner of the Policyholder. NOTE: Children of a Domestic Partner are eligible only as long as the Domestic Partner is covered, and they must qualify as a Domestic Partner's Dependent for Federal tax purposes.
    3. Stepchildren who reside with you.
    4. Dependents of your Dependent children who reside with you or your covered Dependent child and are chiefly Dependent on you or your covered Dependent child for support and maintenance.
    5. Children for whom you are the legal guardian.
    6. Children who are required to be covered by reason of a Qualified Medical Child Support Order. Delta Dental
    7. Children who become disabled prior to reaching Delta Dental's limiting age may continue coverage after the limiting age, if:
        - they are primarily Dependent upon you; and
        - are incapable of self-sustaining employment because of developmental delay, mental illness or mental disorder or physical disability.

Under the Affordable Care Act ("ACA"), pediatric dental coverage for children is provided up to age 19. Once an individual no longer qualifies for pediatric dental coverage under the ACA, Delta Dental of Minnesota ("Delta Dental") can provide dental care services for adult members ages 19 and older if they choose to enroll in an individual plan through Delta Dental.

Effective Dates of Coverage

Eligible Subscribers:

Your insurance begins on the first of the month following the date we receive and approve your application, enrollment fee and initial premium. Your election continues until December 31, so long as the premium is paid, subject to the Grace Period.

Eligible Dependents:

Your eligible Dependents, as defined, are covered under this Policy:

a) On the date you first become eligible for coverage, if Dependent coverage is provided or elected.

b) On the date you first acquire eligible Dependents, or add Dependent coverage.

c) On the date a new Dependent is acquired if you are already carrying Dependent coverage.

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

The eligibility of all Covered Persons, for the purposes of receiving benefits under the Policy, shall, at all times be contingent upon the applicable scheduled payment having been made for such Covered Person.

Family Status Change

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

- Change in legal marital status such as marriage or divorce.
- Change in number of Dependents in the event of birth, adoption, placement for adoption or death.
- Change in your or your spouse's employment – either starting or losing a job.
- Change in your or your spouse's work schedule, such as going from full-time to part-time or part-time to full-time, or beginning or ending an unpaid leave of absence.
- Change in Dependent status, such as if a child reaches maximum age under Delta Dental.
- Change in residence or work location so you are no longer eligible for your current health plan.
- Qualification for Medicare or Medicaid.
- Loss of other coverage.

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

If a Dependent is no longer eligible under the current policy due to one of the Family Status Changes listed above, they have the right to continue coverage under their own policy and to obtain a policy in their own name. If you need to enroll in your own policy due to a family status change, you may enroll at www.DeltaDentaMN.org or contact Customer Service at the number listed on your ID card for assistance.

If you experience one of the following eligible Family Status Changes during the year, you have 31 days *(except in the case of the birth/adoption of a child - See Effective Dates of Coverage as stated above)* from

the event to change your elections. You may obtain a Family Status Change Form by calling Customer Service at (855) 643-3582. All changes are effective the date of the change.

Termination of Coverage

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

a) The date you cease to be eligible;

b) (For any covered Dependents), the day your Dependent ceases to be a Dependent, as defined in the Eligibility section of this booklet;

c) The last day of the month for which a premium has not been paid, subject to the grace periods; or

d) The date the policy ends.

Delta Dental reserves the right to terminate Delta Dental, in whole or in part, at any contract renewal date by giving you written notice at least 31 days prior to such contract renewal date. Termination of Delta Dental will result in loss of benefits for all covered persons. If the policy is terminated, the rights of the covered persons are limited to covered expenses incurred before termination.

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 Delta Dental.

We reserve the right to terminate the policy, in whole or in part, by giving you written notice at least 31 days advance notice. Termination of the policy will result in loss of coverage for all covered persons. If the policy is terminated, the rights of the covered persons are limited to covered services incurred before termination. Termination is without prejudice to any claim originating while the policy was in force.

We will only increase the premiums or decrease the benefits provided in this policy effective with a 31 days prior written notice.

PLAN PAYMENTS

Participating Dentist Network

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

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

Delta Dental's allowable charge. A Delta Dental Premier® dentist has also agreed to file the claim directly with Delta Dental.

Names of Participating Dentists can be obtained, upon request, by calling Delta Dental, or from Delta Dental's web site at www.DeltaDentalMN.org/find-a-dentist. Refer to the General Information section of this booklet for detailed information on how to locate a participating provider using Delta Dental's web site.

Covered Fees

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

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

Claim Payments

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

Delta Dental Premier® Dentists:

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

Delta Dental PPO™ Dentists:

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

Nonparticipating Dentists:

Claim payments are based on Delta Dental's Payment Obligation, which for nonparticipating dentists is the treating dentist's submitted charge or the amount established solely by Delta Dental, whichever is less. Claim

payments are sent directly to the Covered Person unless benefits are authorized by the Covered Person to be paid directly to the provider.

THE COVERED PERSON IS RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY THE NONPARTICIPATING DENTIST.

Claim and Appeal Procedures

Proof of Loss

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

Initial Claim Determinations

An initial benefit determination on your claim or an initial request for additional information will be made within 15 days after receipt of your claim. You will receive written notice of this benefit determination if you have any liability or request for additional information. If the extension is needed for us to get additional information from you, the notice will describe the specific information we need. You will have 45 days from the receipt of the notice to provide the information. Without complete information, your claim will be denied.

Appeals

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

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

Delta Dental of Minnesota
Attention: Professional Services Appeals and
Grievances PO Box 30416
Lansing, MI 48909

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

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

benefit determination. If, after review, we continue to deny the claim, you will be notified in writing.

Authorized Representative

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

GENERAL INFORMATION

Health Plan Issuer Involvement

Delta Dental is the health plan issuer involved with Delta Dental. Its address is stated on the back cover of this booklet. The benefits under Delta Dental are guaranteed by Delta Dental under the Contract. Delta Dental will review claims incurred and submitted for enrollees under prior coverage with Delta Dental in determining benefits under this coverage.

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

Privacy Notice

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

How to Find a Participating Dentist

A real-time listing of participating dentists is available in an interactive directory at Delta Dental's user-friendly web site, www.DeltaDentalMN.org. Delta Dental highly recommends use of the web site for the most accurate network information.

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

If you do not have Internet access, you can also find a network dentist or verify that your current dentist is in the network by:

- Asking the dental office representative when you call to schedule a dentist appointment.
- Contacting our Customer Service Center at (855) 643-3582. Customer Service hours are 7a.m. - 7

p.m. CT, Monday through Friday.

Using Your Dental Policy
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 services 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.

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

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

is nonparticipating, claim forms are available by calling (855) 643-3582.

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

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

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

* YOUR DELTA DENTAL GROUP NUMBER
* YOUR IDENTIFICATION NUMBER (your Dependents must use **YOUR** identification number)
* YOUR BIRTHDAY AND THE BIRTH DATES OF YOUR SPOUSE AND DEPENDENT CHILDREN

DELTA DENTAL OF MINNESOTA
NOTICE OF INFORMATION
PRACTICES

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

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

Our Permitted Uses and Disclosures of Your Protected Health Information

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

Treatment: We may disclose PHI to your dentist(s) for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seek information from us as to whether the service has been previously provided.
Payment: We use and disclose your PHI in order to fulfill our duty to provide your coverage, determine your benefits, and make payment for services provided to you. For example, we may use and disclose your PHI in order to process your claims.

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

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

Unless you object, we may disclose your PHI to a family member, other relative, person authorized by law, or any other person you identify as involved in your care or the payment related to your care. Only PHI relevant to that person's involvement in your care or the payment related to your care will be disclosed. You can restrict this disclosure at any time, subject to certain limitations.

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

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

Individual Rights

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

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

use or disclosure is considered a “breach” as defined by the HIPAA Privacy Rules.

Complaints

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

Our Legal Duty

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

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

Customer Service
PO Box 1886
Indianapolis, IN 46206-1886
(855) 643-3582

DELTA DENTAL OF MINNESOTA

DELTA DENTAL OF MINNESOTA
Administrative Offices

PO Box 1886
Indianapolis, IN 46206-1886
(855) 643-3582
www.DeltaDentalMN.org