

# **COMPREHENSIVE ENHANCED**

utilizing the  
**Delta Dental PPO**  
and  
**Delta Dental Premier Networks**

Dental Benefit Plan Summary

**The College of St. Scholastica**  
**Buy-up Plan**  
Group Number 51068

## **DENTAL BENEFIT PLAN SUMMARY**

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

The College of St. Scholastica  
(**GROUP**)

This Program has been established and is maintained and administered in accordance with the provisions of your Group Dental Plan Contract Number **51068** issued by Delta Dental of Minnesota (**PLAN**).

### **IMPORTANT**

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

### **DELTA DENTAL OF MINNESOTA**

#### **Administrative Offices**

National Dedicated Service Center  
P.O. Box 59238  
Minneapolis, Minnesota 55459  
(651) 406-5901 or (800) 448-3815  
[www.deltadentalmn.org](http://www.deltadentalmn.org)

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

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

*Delta Dental of Minnesota understands that medical information about you and your health is personal, and we are committed to protecting your medical information. 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").*

**Our Permitted Uses and Disclosures of Your Protected Health Information**

We use and disclose PHI about you 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 as to whether the service has been previously provided.

**Payment:** We 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 your PHI in order to process your claims.

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

We may be asked by the sponsor of your health plan to provide your PHI to the sponsor. If we are asked to do so, we intend to honor such requests unless we are prohibited by law from doing so.

We may use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may give out PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We provide PHI when otherwise required by law, such as for law enforcement in specific circumstances, or for judicial or administrative proceedings. In any other situation, 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 may change our policies at any time. Before we make a significant change in our policies, we will change our notice and send the new notice to you. You can also request a copy of our notice at any time. For more information about our privacy practices, visit our web site at [www.deltadentalmn.org](http://www.deltadentalmn.org).

**Individual Rights**

In most cases, you have the right to view or get a copy of your PHI. 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.

### **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, or if you have any questions, complaints or concerns, please contact:

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

You may also obtain a copy of this notice at our web site [www.deltadentalmn.org](http://www.deltadentalmn.org).

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**SUMMARY OF DENTAL BENEFITS**

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

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

**Benefit Maximums**

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

**Deductible**

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

The deductible does not apply to Diagnostic and Preventive services.

**Coverage Year**

A Coverage Year is a 12-month period in which deductibles and benefit maximums apply. Your Coverage Year is January 1 to December 31.

## **DESCRIPTION OF COVERED PROCEDURES**

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### **Pretreatment Estimate** (Estimate of Benefits)

IT IS RECOMMENDED THAT A PRETREATMENT ESTIMATE BE SUBMITTED TO THE PLAN PRIOR TO TREATMENT IF YOUR DENTAL TREATMENT INVOLVES MAJOR RESTORATIVE, PERIODONTICS, PROSTHETICS OR ORTHODONTIC CARE (SEE DESCRIPTION OF COVERAGES), TO ESTIMATE THE AMOUNT OF PAYMENT. THE PRETREATMENT ESTIMATE IS A VALUABLE TOOL FOR BOTH THE DENTIST AND THE PATIENT. SUBMISSION OF A PRETREATMENT ESTIMATE ALLOWS THE DENTIST AND THE PATIENT TO KNOW WHAT BENEFITS ARE AVAILABLE TO THE PATIENT BEFORE BEGINNING TREATMENT. THE PRETREATMENT ESTIMATE WILL OUTLINE THE PATIENT'S RESPONSIBILITY TO THE DENTIST WITH REGARD TO CO-PAYMENTS, DEDUCTIBLES AND NON-COVERED SERVICES AND ALLOWS THE DENTIST AND THE PATIENT TO MAKE ANY NECESSARY FINANCIAL ARRANGEMENTS BEFORE TREATMENT BEGINS. THIS PROCESS DOES NOT PRIOR AUTHORIZE THE TREATMENT NOR DETERMINE ITS DENTAL OR MEDICAL NECESSITY. THE ESTIMATED DELTA DENTAL PAYMENT IS BASED ON THE PATIENT'S CURRENT ELIGIBILITY AND CURRENT AVAILABLE CONTRACT BENEFITS. THE SUBSEQUENT SUBMISSION OF OTHER CLAIMS, A CHANGE IN ELIGIBILITY, A CHANGE IN THE CONTRACT COVERAGE OR THE EXISTENCE OF OTHER COVERAGE MAY ALTER THE DELTA DENTAL FINAL PAYMENT AMOUNT AS SHOWN ON THE PRETREATMENT ESTIMATE FORM.

After the examination, your dentist will establish the dental treatment to be performed. If the dental treatment necessary involves major restorative, periodontics, prosthetics or orthodontic care, a participating dentist should submit a claim form to the Plan outlining the proposed treatment.

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

### **Benefits**

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

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

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

**Delta Dental of Minnesota does not determine whether a service submitted for payment or benefit under this Plan is a dental procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. Delta Dental of Minnesota 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. Other**

dental services may be recommended or prescribed by your dentist, which are dentally necessary, offer you an enhanced cosmetic appearance, or are more frequent than covered by the Plan. While these services may be prescribed by your dentist and are dentally necessary for you, they may not be a dental service that is benefited by this Plan or they may be a service where the Plan provides a payment allowance for a service that is considered to be optional treatment. If the Plan gives you a payment allowance for optional treatment that is covered by the plan, you may apply this Plan payment to the service prescribed by your dentist which you elected to receive. Services that are not covered by the Plan or exceed the frequency of Plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for dental services that are not covered or benefited by the Plan. Determination of services necessary to meet your individual dental needs is between you and your dentist.

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

#### PREVENTIVE CARE (Diagnostic & Preventive Services)

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**Oral Evaluations** - Any type of evaluation (checkup or exam) is covered 1 time per 6-month period.

NOTE: Comprehensive oral evaluations will be benefited 1 time per dental office, subject to the 1 time per 6-month period limitation. Any additional comprehensive oral evaluations performed by the same dental office will be benefited as a periodic oral evaluation and will be subject to the 1 time per 6-month period.

#### Radiographs (X-rays)

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

#### Dental Cleaning

- **Prophylaxis or Periodontal Maintenance** - Any combination of these procedures is covered 2 times per 12-month period.

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

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

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

**Fluoride Treatment** (Topical application of fluoride) - Covered 2 times per 12-month period for dependent children through the age of 13.

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

**Space Maintainers** - Covered 1 time per lifetime on eligible dependent children through the age of 15 for extracted primary posterior (back) teeth.

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

**Sealants** - Covered 1 time per 3-year period for permanent first and second molars of eligible dependent children through the age of 15.

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

**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.

## **BASIC SERVICES**

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

### **Composite (white) Resin Restorations**

- **Anterior (front) Teeth** - Treatment to restore decayed or fractured permanent or primary anterior teeth.
- **Posterior (back) Teeth** - Treatment to restore decayed or fractured permanent or primary posterior (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 the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

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

### **Other Basic Services**

- **Restorative cast post and core build-up, including pins and posts** - See benefit coverage description under Complex or Major Restorative Services.
- **Pre-fabricated or Stainless Steel Crown** - Covered 1 time per 24-month period for eligible dependent children through the age of 18.
- **Consultations** – Covered 1 time per 12-month period.

## **Adjunctive General Services**

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

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

- **Analgesia, Anxiolysis Nitrous Oxide**

EXCLUSIONS - Coverage is NOT provided for:

1. Deep sedation/general anesthesia, analgesic agents, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care.
2. Case presentation and office visits.
3. Athletic mouthguard, enamel microabrasion, and odontoplasty.
4. Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes, but is not limited to whitening agents or tooth bonding.
5. Placement or removal of sedative filling, base or liner used under a restoration.

## **BASIC ENDODONTIC SERVICES (NERVE OR PULP TREATMENT)**

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### **Endodontic Therapy on Primary Teeth**

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

### **Endodontic Therapy on Permanent Teeth**

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

### **Complex or other Endodontic Services**

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

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

EXCLUSIONS - Coverage is NOT provided for:

1. Retreatment of endodontic services that have been previously benefited under the Plan.
2. Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
3. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
4. Intentional reimplantation.

## **PERIODONTICS (GUM & BONE TREATMENT)**

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

- **Periodontal scaling & root planing** - Covered 1 time per 24 months.
- **Full mouth debridement** - Covered 1 time per 36 months.

**Crown lengthening** – Covered 1 time per 12 months.

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

- **Gingivectomy/gingivoplasty** – Covered 1 time per 12-month period.
- **Gingival curettage**
- **Gingival flap**
- **Apically positioned flap**
- **Mucogingival surgery**
- **Osseous surgery**
- **Bone replacement graft**
- **Pedicle soft tissue graft**
- **Free soft tissue graft**
- **Subepithelial connective tissue graft**
- **Soft tissue allograft**
- **Combined connective tissue and double pedicle graft**
- **Distal/proximal wedge**

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

EXCLUSIONS - Coverage is NOT provided for:

1. Bacteriologic tests for determination of periodontal disease or pathologic agents.
2. The controlled release of therapeutic agents or biologic materials used to aid in soft tissue and osseous tissue regeneration.
3. Provisional splinting, temporary procedures or interim stabilization of teeth.
4. Deep sedation/general anesthesia, analgesic agents or therapeutic drug injections, drugs, or medicaments for non-surgical and surgical periodontal care, regardless of the method of administration.

## **ORAL SURGERY (TOOTH, TISSUE, OR BONE REMOVAL)**

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### **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**

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

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

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

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

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

### **LIMITATIONS**

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

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

**EXCLUSIONS - Coverage is NOT provided for:**

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

**COMPLEX OR MAJOR RESTORATIVE SERVICES**

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

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

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

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

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

**Implant Crowns** - See Prosthetic Services.

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

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

**Canal prep & fitting of preformed dowel & post**

**Veneers**

**Occlusal guards**

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
2. 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.
3. Placement or removal of sedative filling, base or liner used under a restoration.
4. Temporary, provisional or interim crown.
5. Occlusal adjustments.

**PROSTHETIC SERVICES (DENTURES, PARTIALS, AND BRIDGES)**

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**Reline, Rebase, Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s)**

- Covered when:

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

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

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

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

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

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

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

**Implant Supported Fixed and Removable Prosthetic (Crowns, Bridges, Partials and Dentures)** - A restoration that is retained, supported and stabilized by an implant. Implants and related services are NOT covered.

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.

**Restorative cast post and core build-up, including pins and posts** - Covered 1 time per 5-year period when done in conjunction with covered fixed prosthetic services.

**EXCLUSIONS - Coverage is NOT provided for:**

1. The replacement of an existing partial denture with a bridge.
2. Initial installation of full or partial dentures 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. NOTE: This exclusion only applies to new hires effective after January 1, 2008.
3. 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. NOTE: This exclusion only applies to new hires effective after January 1, 2008.
4. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
5. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
6. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
7. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
8. Services or supplies that have the primary purpose of improving the appearance of your teeth.
9. Placement or removal of sedative filling, base or liner used under a restoration.
10. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
11. Coverage shall be limited to the least expensive professionally acceptable treatment.

**Exclusions**

Coverage is NOT provided for:

- a) Dental services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving Medical Assistance pursuant to Minnesota Statute Section 62A.045.
- b) Dental services or health care services not specifically covered under the Group Dental Plan Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).
- c) New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.
- d) Dental services performed for cosmetic purposes. NOTE: Dental services are subject to post-payment review of dental records. If services are found to be cosmetic, we reserve the right to collect any payment and the member is responsible for the full charge.
- e) Dental services completed prior to the date the Covered Person became eligible for coverage.
- f) Services of anesthesiologists.

- g) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.
- h) Deep sedation/general anesthesia, analgesic agents, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.
- i) Dental services performed other than by a licensed dentist, licensed physician, his or her employees.
- j) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- k) 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.
- m) Orthodontic treatment services, unless specified in this Dental Benefit Plan Summary as a covered dental service benefit.
- n) Case presentations and office visits.
- o) Incomplete, interim or temporary services.
- p) Athletic mouth guards, enamel microabrasion and odontoplasty.
- q) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.
- r) 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) Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
- v) Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).
- w) The replacement of an existing partial denture with a bridge.
- x) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- y) Provisional splinting, temporary procedures or interim stabilization.
- z) 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) Occlusal adjustments.

### **Limitations**

- a) **Reconstructive Surgery:** benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, to the extent as required by MN Statute 62A.25 provided, however, that such services are dental reconstructive surgical services.

- b) Benefits for inpatient or outpatient expenses arising from dental services up to age 18, including orthodontic and oral surgery services, involved in the management of birth defects known as cleft lip and cleft palate as required by Minnesota Statutes Section 62A.042. For Programs without orthodontic coverage: Dental orthodontic services not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit program. For Programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this plan shall be primary and the other policy or contract shall be secondary.

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

### **Post Payment Review**

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

### **Optional Treatment Plans**

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

## **ELIGIBILITY**

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Covered Persons under this Program are:

### **Employees**

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

### **Dependents**

A) Spouse, meaning:

- 1. Married;
- 2. Legally separated;

B) Unmarried dependent children to the age of 25, including:

- 1. Natural-born and legally adopted children (including children placed with you for legal adoption. NOTE: A child's placement for adoption terminates upon the termination of the legal obligation of total or partial support.
- 2. Stepchildren who reside with you.
- 3. Grandchildren who are financially dependent on you and reside with you.

4. Children who are required to be covered by reason of a Qualified Medical Child Support Order. You can obtain, without charge, a copy of procedures governing Qualified Medical Child Support Orders ("QMCSOs") from the Plan Administrator.
5. Children who become handicapped prior to reaching the Plan's limiting age if:
  - they are primarily dependent upon you; and
  - are incapable of self-sustaining employment because of physical handicap, mental retardation, mental illness or mental disorders

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

### **Effective Dates of Coverage**

Eligible Employee:

You are eligible to be covered under this Program when the Program first became effective, January 1, 2008, or if you are a new employee of the Group, on the first of the month following date of hire for non-union employees and first of the month following 60 days of employment for union employees.

Faculty employees are eligible to be covered when they work 25 hours or more per week.

Staff employees are eligible to be covered when they work 30 hours or more per week.

Union employees are eligible to be covered when they work 40 hours or more per week.

Return to work guidelines: You are eligible to be covered on the first of the month following date of hire.

Status change: You are eligible to be covered on the first of the month following date of status change.

Eligible Dependents:

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

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

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

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

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

### **Open Enrollment**

The Open Enrollment under this Contract shall be held annually, November 1 to December 31.

## **Family Status Change**

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

- Change in legal marital status such as marriage or divorce.
- Change in number of dependents in the event of birth, adoption, or death.
- Change in your or your spouse's employment - either starting or losing a job.
- Change in your or your spouse's work schedule, such as going from full-time to part-time or part-time to full-time, or beginning or ending an unpaid leave of absence.
- Change in dependent status, such as if a child reaches maximum age under the Plan.
- Change in residence or work location so you are no longer eligible for your current health plan.
- Qualification for Medicare or Medicaid.
- 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 not consistent to drop your dental coverage altogether.

If you experience one of the above eligible Family Status Changes during the year, you have 31 days (*except in the case of the birth/adoption of a child - see Effective Dates of Coverage as stated above*) from the event to change your elections. If you do not change your benefits within 31 days of the event, you will not be allowed to make changes until the next Open Enrollment period. You may obtain a Family Status Change Form by contacting your Employer. All changes are effective the date of the change.

## **The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**

**Continuation of Benefits:** Covered employees who are absent due to service in the uniformed services and/or their covered dependents may continue coverage under USERRA for up to 24 months after the date the covered employee is first absent due to uniformed service duty. To continue coverage under USERRA, covered employees and/or their dependents should contact their Employer.

**Eligibility:** A covered employee is eligible for continuation under USERRA if he or she is absent from employment because of service in the uniformed services as defined in USERRA. This includes voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard or the commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

Covered employees and dependents who have coverage under the Plan immediately prior to the date of the covered employee's covered absence are eligible to elect continuation under USERRA.

**Contribution Payment:** If continuation of Plan coverage is elected under USERRA, the covered employee or covered dependent is responsible for payment of the applicable cost of COBRA coverage. If, however, the covered employee is absent for not longer than 31 calendar days, the cost will be the amount the covered employee would otherwise pay for coverage (at employee rates). For absences exceeding 31 calendar days, the cost may be up to 102% of the cost of coverage under the Plan. This includes the covered employee's share and any portion previously paid by the Employer.

**Duration of Coverage:** Elected continuation coverage under USERRA will continue until the earlier of:

- 24 months, beginning the first day of absence from employment due to service in the uniformed services;

- the day after the covered employee fails to apply for or return to employment as required by USERRA, after completion of a period of service;
- the early termination of USERRA continuation coverage due to the covered employee's court-martial or dishonorable discharge from the uniformed services; or
- the date on which this Plan is terminated so that the covered employee loses coverage.

Covered employees should contact their Employer with any questions regarding continuation coverage and notify the Employer of any changes in marital status or a change of address.

Reemployment: An individual whose coverage under the Plan was terminated by reason of service in the uniformed services and who did not continue coverage during leave must, nevertheless, be entitled to reinstatement of coverage upon reemployment.

### Termination of Coverage

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

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

For extended eligibility, see Continuation of Coverage.

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

### Continuation of Coverage (COBRA)

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

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

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

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

#### 1. Choosing Continuation

If you lose coverage, your employer must notify you of the option to continue coverage within 10 days after employment ends. If coverage for your dependent ends because of divorce, legal separation, or any other change in dependent status, you or your covered dependents must notify your employer within 60 days.

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

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

## 2. Second qualifying event

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

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

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

## 3. Terminating Continuation of Coverage - COBRA

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

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

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

## **PLAN PAYMENTS**

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### **Participating Dentist Network**

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

A Delta Dental PPO network dentist is a dentist who has signed Delta Dental PPO agreement with Delta Dental of Minnesota. The dentist has agreed to accept the Delta Dental PPO Maximum Amount Payable 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 Maximum Amount Payable. A Delta Dental PPO dentist has also agreed to file the claim directly with Delta Dental.

Names of Participating Dentists can be obtained, upon request, by calling Delta, or from the Plan's internet web site at [www.deltadentalmn.org](http://www.deltadentalmn.org). Refer to the General Information section of this booklet for detailed information on how to locate a participating provider using the Plan's internet web site.

## **Covered Fees**

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

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

## **Claim Payments**

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

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

Delta Dental Premier Dentists:

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

Delta Dental PPO Dentists:

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

Nonparticipating Dentists:

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

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

### **Coordination of Benefits (COB)**

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

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

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

### **Assignment of Benefits**

Any benefits which may be payable under this dental benefit Plan are not assignable.

### **Claim and Appeal Procedures**

#### Initial Claim Determinations

All claims should be submitted within 12 months of the date of service. An initial benefit determination on your claim will be made within 30 days after receipt of your claim. You will receive written notification of this benefit determination. The 30-day period may be extended for an additional 15 days if the claim determination is delayed for reasons beyond our control. In that case, we will notify you prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which we expect to render a decision. If the extension is necessary to obtain additional information from you, the notice will describe the specific information we need, and 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 within 180 days from the claim denial. We will make a benefit determination within 60 days following receipt of your appeal.

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

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

You may submit written comments, documents, or other information in support of your appeal. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim (whether or not presented or available at the initial determination) and the initial determination will not be given any weight.

The review will be conducted by someone different from the original decision-makers and without deference to any prior decision. Because all benefit determinations are based on a preset schedule of dental services eligible under your plan, claims are not reviewed to determine dental necessity or appropriateness. In all cases where professional judgment is required to determine if a procedure is covered under your plan's schedule of benefits, we will consult with a dental professional who has appropriate training and experience. In such a case, this professional will not be the same individual whose advice was obtained in connection with the initial adverse benefit determination (nor a subordinate of any such individual). In addition, we will identify any dental professional whose advice was obtained on our behalf, without regard to whether the advice was relied upon 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**

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### **Health Plan Issuer Involvement**

Delta Dental is the health plan issuer involved with the Plan. Its address is stated on the last page of this document. The benefits under the Plan are guaranteed by Delta Dental under the Contract (for insured plans).

### **Privacy Notice**

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

### **How to Find a Participating Dentist**

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

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

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

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

### **Using Your Dental Program**

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

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

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

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

Delta Dental of Minnesota National Dedicated Service Center - (651) 406-5901 or (800) 448-3815

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

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

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

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

### **Cancellation and Renewal**

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

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

# **DELTA DENTAL OF MINNESOTA**

## **FOR CLAIMS AND ELIGIBILITY**

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

## **FOR APPEALS**

P.O. Box 551  
Minneapolis, Minnesota 55440-0551

## **CORPORATE LOCATION**

3560 Delta Dental Drive  
Eagan, Minnesota 55122-3166  
(651) 406-5900 or (800) 328-1188  
[www.deltadentalmn.org](http://www.deltadentalmn.org)

## **CORPORATE MAILING ADDRESS**

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

Approved 7/2008