



# Individual and Family Plan C

Delta Dental of Minnesota

**We're pleased to be your partner in maintaining better health, through oral health.**

## Experience the Delta Dental Difference

- The nation's largest network of dental participating providers
- Best-in-class customer service and expert claims processing
- Added value benefits that go beyond dental, included with your dental plan
- See any dentist, but enjoy the greatest cost savings (and no paperwork) with in-network providers

Services Covered Immediately:	Plan C
<b>Diagnostic/Preventive</b> - Routine exams, X-rays and cleanings, including periodontal cleaning - once every 6 months	100%
<b>Basic Restorative</b> - Fillings and sealants	50%**
<b>Oral Surgery</b> - Including extractions	N/A
<b>Root Canals</b> - Endodontics	N/A
Services Covered After 12 Months*:	
<b>Periodontal Care</b> - Treatment of gum disease, surgical/non-surgical treatment	N/A
<b>Crown and Cast Restorations</b>	N/A
<b>Prosthodontics</b> - Dentures, partial dentures and bridges	N/A
Additional Plan Details:	
<b>Annual Coverage Maximum Per Person</b>	\$500
<b>Annual Deductible Per Person</b>	\$100 Does not apply to Diagnostic/Preventive
<b>Utilizes Delta Dental Network(s):</b>	Delta Dental PPO <sup>SM</sup> Delta Dental Premier <sup>®</sup>

\*\*3 month waiting period on all Basic Services.

Individual Dental 18+	Plan C (per month)
Single Applicant (you)	\$24.60
Single Applicant +1	\$48.00
Family	\$86.80

\*waiting period may be waived with prior comparable coverage

## So what are you waiting for?

Speak with a licensed representative at  
**1-866-764-5350** or visit  
**ThePowerOfSmile.com**



# **Delta Dental Individual & Family**

## **Plan C**

### **Dental Benefit Summary**

## DENTAL BENEFIT PLAN SUMMARY

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

Delta Dental Individual & Family - Plan C

This Program has been established and is maintained and administered in accordance with the provisions of your Dental Plan Policy Number 3700 issued by Delta Dental of Minnesota (Delta Dental).

READ YOUR MASTER POLICY CAREFULLY. This introductory page entitled, "Dental Benefit Plan Summary," is a summary **only** of some of the important features of your Master Policy. Contained within this booklet, you will find the Master Policy, which sets forth in detail the rights and obligations of both you and Delta Dental of Minnesota. Please note that the Master Policy is NOT the entire contract itself, which is made up of the Master Policy, individual enrollment forms and the Benefit Plan Summary. Additionally, the Benefit Plan Summary, which includes covered benefits, exclusions, eligibility and payment, is also contained within this booklet and begins on page 1. It is THEREFORE IMPORTANT THAT YOU READ THE MASTER POLICY AND THE BENEFIT PLAN SUMMARY CAREFULLY.

**RIGHT TO CANCEL:** The Policyholder may cancel this Contract by delivering or mailing a written notice to Delta Dental of Minnesota, P.O. Box 330, Minneapolis, MN 55440-0330 and by returning the Contract before midnight of the tenth day after the date the Policyholder receives the Contract. Notice given by mail and return of the policy or contract by mail are effective on being postmarked, properly addressed and postage prepaid. Delta Dental shall, within ten days after it receives notice of cancellation and the returned Contract, void the policy from its inception and return the difference between any premiums paid by the Policyholder, and any benefits paid by Delta Dental on behalf of the Policyholder and/or any covered Dependents under the Contract.

**DELTA DENTAL OF MINNESOTA**

BY:



**DELTA DENTAL OF MINNESOTA**

AND BY:



TITLE: Assistant Secretary

TITLE: President

DATE: October 1, 2015

DATE: October 1, 2015

**DELTA DENTAL OF MINNESOTA**

Administrative Offices

P.O. Box 330

Minneapolis, Minnesota 55440-0330

(651)406-5955 or (888)223-2954

[www.deltadentalmn.org](http://www.deltadentalmn.org)

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## **Delta Dental Individual & Family Master Policy**

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

By paying the first premium and accepting this Policy, the Policyholder agrees to be bound by the terms of this Policy.

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

Individuals currently enrolled in another Delta Dental group or individual dental plan are not eligible for coverage.

### **PREMIUM CALCULATIONS AND PAYMENT**

Premiums are payable on a monthly, quarterly or annual basis, unless Delta Dental agrees to some other mode of payment. Premiums must be paid to Delta Dental at the following address:

Delta Dental of Minnesota  
P.O. Box 86  
Minneapolis, MN 55486-0944

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.

Delta Dental may change the premium for insurance provided under this Policy by giving the Policyholder a written notice at least 31 days prior to any change.

### **POLICY PROVISIONS**

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** (a) After two years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the Policy) commencing after the expiration of such two year period. After this Policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. (b) No claim for loss incurred or disability (as defined in the Policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

**GRACE PERIOD:** A Grace Period of 31 days will be granted for the payment of premiums after the first premium. The coverage under this Policy will continue in force during such Grace Period.

**PROOFS OF LOSS:** Written proof of loss must be furnished to Delta Dental at its said office in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished 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.

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

**TIME OF PAYMENT OF CLAIMS:** Indemnities payable under this Policy for any loss other than loss for which this policy provides periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

**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.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** Delta Dental at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

**DENTAL BENEFIT SUMMARY:** We will issue an individual Dental Benefit Summary describing the benefits under this Policy.

**CONFORMITY TO LAW:** Any provision of this Policy, which on its Effective Date, is in conflict with the laws of the state in which the Policy 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.

**POLICY TERM:** This Policy continues for a period of one (1) year from its Effective Date, so long as the premium is paid, subject to the Grace Period. If the Policyholder elects coverage and subsequently drops coverage, the Policyholder and any dependents will not be allowed to re-enroll in the plan.

After your initial twelve (12) month coverage period you may terminate this policy or premium due date by giving written notice to Delta Dental 31 days prior to any premium due date. Delta Dental reserves the right to terminate the Policy, 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 the Policy 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.

**CHANGE OF BENEFICIARY:** Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or

beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

REINSTATEMENT: If any renewal premium be 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. If Delta Dental or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Delta Dental or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless Delta Dental has previously notified the Policyholder in writing of its disapproval of such application.

#### **DENTAL BENEFIT SUMMARY PROVISIONS MADE PART OF THE POLICY**

The remainder of this Policy consists of provisions shown in the Dental Benefit Summary as issued to the Policyholder. The provisions described in the Table of Contents are part of this Policy. Amendments, if any, adding or changing the provisions of the Summary are also made part of this Policy.

## DESCRIPTION OF COVERED PROCEDURES

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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 Dental is different for Delta Dental PPO<sup>SM</sup> dentists, Delta Dental Premier® dentists and nonparticipating dentists. If you see a nonparticipating dentist, your out-of-pocket expenses may increase.

	<u>Delta Dental PPO</u>	<u>Delta Dental Premier</u>
Diagnostic and Preventive Services .....	100%	100%
Basic Restorative Services* .....	50%	50%

\* 3 month waiting period must be satisfied before benefits can be received.

### Benefit Maximums

The Program pays up to a maximum of \$500.00 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 \$100.00 deductible per Covered Person each Coverage Year.

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 January 1.



## **Pretreatment Estimate**

(Estimate of Benefits)

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

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

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

## **Benefits**

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

As a condition precedent to the approval of claim payments, 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.

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

the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any coinsurance or deductible you may have. Services that are not covered by the Plan or exceed the frequency of Plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for dental services that are not covered or benefited by the Plan. The decision as to what dental care treatment is best for you is solely between you and your dentist.

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

### **Waiting Periods**

Waiting periods of **12 months for Periodontics, Complex and Major Restorative Services and Prosthodontic Services** will apply before you are eligible for reimbursement.

## **DIAGNOSTIC AND 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 limitation.

### **Radiographs (X-rays)**

- **Bitewings** - Covered at 1 series of bitewings per 12-month period for Covered Persons through the age of 17; 1 series of bitewings per 24-month period for Covered Persons age 18 and over.
- **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 2 series per 24-month period.

### **Dental Cleaning**

- **Prophylaxis or Periodontal Maintenance** - Any combination of these procedures is covered 1 time per 6-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 1 time per 12-month period for dependent children through the age of 18.

EXCLUSIONS - Coverage is NOT provided for:

1. Oral hygiene instructions.

## **BASIC RESTORATIVE SERVICES**

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

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

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

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

If you chose to have a composite restoration on a posterior (back) tooth, our payment will be limited to the same allowances for an amalgam (silver filling). You must pay the difference in cost between the covered benefit and the dentist's charges, 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.

### **Other Preventive and Basic Services**

- **Pre-fabricated or Stainless Steel Crown** - Covered 1 time per 60-month period for eligible dependent children through the age of 18.
- **Sealants or Preventive Resin Restorations** - Any combination of these procedures is covered 1 time per lifetime for permanent first and second molars of eligible dependent children through the age of 15.
- **Space Maintainers** - Covered 1 time per lifetime on eligible dependent children through the age of 16 for extracted primary posterior (back) teeth.

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

### **Adjunctive General Services**

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

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

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

1. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care.
2. Case presentation and office visits.
3. Athletic mouthguard, enamel microabrasion, and odontoplasty.
4. Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes but is not limited to whitening agents, tooth bonding and veneers.
5. Placement or removal of sedative filling, base or liner used under a restoration.
6. Restorative cast post and core build-up, including pins and posts.
7. Restorations placed for preventive or cosmetic purposes.
8. Pulp vitality tests.
9. Diagnostic casts.
10. Adjunctive diagnostic tests.
11. 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.

**EXCLUSIONS**

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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 your 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, unless specified in this Dental Benefit Plan Summary as a covered dental service benefit.
- n) Case presentations, office visits and consultations.
- o) Incomplete, interim or temporary services.
- p) 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.
- 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 the plan.
- 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) Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
- y) Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).
- z) Services for the replacement of an existing partial denture with a bridge.
- aa) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- bb) Provisional splinting, temporary procedures or interim stabilization.
- cc) Placement or removal of sedative filling, base or liner used under a restoration.
- dd) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
- ee) Oral hygiene instruction.
- ff) Restorative cast post/core or core build-up, including pins and posts.
- gg) Occlusal procedures.
- hh) Restorations placed for preventive or cosmetic purposes.

- ii) Pulp vitality tests.
- jj) Adjunctive diagnostic tests.
- kk) Diagnostic casts.
- ll) Incomplete root canals.
- mm) Cone beam images.
- nn) Anatomical crown exposure.
- oo) Temporary anchorage devices.
- pp) Sinus augmentation.
- qq) Brush biopsy and the accession of a brush biopsy.
- 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.
- tt) Implants and related services.
- uu) Major restorative services.
- vv) Endodontic services.
- ww) Periodontic services.
- xx) Oral surgery/extraction services.
- yy) Crowns, inlays or onlays.
- zz) Repairs and adjustments to prosthetic appliances.
- aaa) Bridges, partial dentures, full dentures, and removable unilateral dentures.
- bbb) Emergency treatment for relief of pain.
- ccc) Orthodontic services.

### **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:

### **Subscribers**

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

### **Dependents, if dependent coverage is elected**

#### **A) Spouse, meaning:**

1. Married;
2. Legally separated;
3. Qualified domestic partner, if all of the following criteria are met:
  - a. are not related by blood closer than permitted under Minnesota 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 to the age of 26, including:**

1. Natural-born and legally adopted children (including children placed with you for legal adoption. NOTE: A child's placement for adoption terminates upon the termination of the legal obligation of total or partial support.
2. Children of the domestic partner. 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. Grandchildren who are financially dependent on and reside with you.
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.
7. Children who become disabled prior to reaching the Policy's limiting age if:



- they are primarily dependent upon you; and
- are incapable of self-sustaining employment by reason of developmental delay, mental illness or disorder or physical disability.

### **Effective Dates of Coverage**

Eligible Policyholders:

Your insurance begins on the first of the month following the date we receive your application, enrollment fee and initial premium. Your election continues for a period of one (1) year from its Effective Date, so long as the premium is paid, subject to the Grace Period.

Policyholders currently enrolled in another Delta Dental group or individual dental plan are not eligible for coverage.

If you elect coverage and subsequently drop coverage, you and any dependents that you have covered will not be allowed to re-enroll in the plan for a period of 24 months from the date coverage was dropped.

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 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 Subscriber who are in active military service are not eligible for coverage under the Program.

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

### **Waiting Periods**

New Eligible Subscribers and their Eligible Dependents will be subject to waiting periods of **12 months for Periodontics, Complex and Major Services and Prosthetic Services.**

### **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, 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 the Policy.
- 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 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 (651) 406-5959 or (800) 704-6993. 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 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.

After your initial twelve (12) month coverage period you may terminate this policy on premium due date by giving written notice to us 31 days prior to any premium due date. Delta Dental reserves the right to terminate the Policy, 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 the Policy 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.

## **PLAN PAYMENTS**

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### **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 Maximum Amount Payable as payment in full for covered dental care. Delta Dental's Delta Dental PPO 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 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. Claim payments are sent directly to the participating provider.

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 Maximum Amount Payable. A Delta Dental Premier dentist has also agreed to file the claim directly with Delta Dental. Claim payments are sent directly to the participating provider.

Names of Participating Dentists can be obtained, upon request, by calling Delta Dental, or from Delta Dental's internet website 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 Delta Dental's internet website.

### **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 participating Delta Dental Premier or Delta Dental PPO dentist with Delta Dental. There may also be a difference in the payment amount if your dentist is not a participating 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 Table of Allowances determined by Delta Dental.

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.

## **Notice of Claim**

Written notice of claim must be given to Delta Dental within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Policyholder or the beneficiary shall be presented to Delta Dental at PO Box 330, Minneapolis, MN 55440.

## **Claim Forms**

Delta Dental, upon receipt of a notice of claim, will furnish to you such forms as are usually furnished for filing proofs of loss. If we do not give you these forms within 15 days after you have filed your notice of claim, you shall be deemed to have complied with the requirements of this policy.

## **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.**

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

### **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 and deductibles as provided under the patient's Delta Dental program.

### **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 and deductibles as provided under the patient's Delta Dental program.

### **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 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 CONTRACT ARE PAID DIRECTLY TO THE COVERED PERSON.

### **Time of Payment of Claim**

Any benefits due under this Policy for any loss other than loss for which this Policy provides periodic payment will be paid immediately upon receipt of due written proof of such loss.

### **Claim and Appeal Procedures**

#### Proof of Loss

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

#### Initial Claim Determinations

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

#### Appeals

In the event that we deny a claim in whole or in part, you have a right to a full and fair review. Your request to review a claim must be in writing and submitted to us within 180 days from the claim denial. We will make a benefit determination within 30 days following receipt of your appeal.

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

Attention: Appeals Unit  
PO Box 551  
Minneapolis, MN 55440-0551

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

The review will be done by 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 website or by calling Customer Service. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

#### **External review**

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

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

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

#### **GENERAL INFORMATION**

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##### **Health Plan Issuer Involvement**

Delta Dental is the health plan issuer involved with the Policy. Its address is stated on the back cover of this booklet. The benefits under the Policy are guaranteed by Delta Dental.

##### **Privacy Notice**

Delta 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 Delta Dental's user friendly website, [www.deltadentalmn.org](http://www.deltadentalmn.org). Delta Dental highly recommends use of the website for the most accurate network information. Go [www.deltadentalmn.org/findadentist](http://www.deltadentalmn.org/findadentist) and enter your zip code, city or state to find local participating dentists. You can also search by dentist or clinic name. The Website 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.
- Contact our Customer Service Center at: (651) 406-5959 or (800) 704-6993. 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 Dental 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 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 (651) 406-5959 or (800) 704-6993 or by logging on to our website at [www.deltadentalmn.org](http://www.deltadentalmn.org).

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 POLICY 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 GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

*Delta Dental of Minnesota is required by law to maintain the privacy of your Protected Health Information, to provide you with this notice of its legal duties and privacy practices with respect to your Protected Health Information and to notify you following a breach of unsecured Protected Health Information. This notice is being issued to comply with the requirements of the Privacy Rules under the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rules"). Individually identifiable information about your past, present or future health 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 use 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. If you are incapacitated or in the event of an emergency, we will exercise professional judgment to determine whether a disclosure of this type is in your best interest.

We may also use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may use and disclose your PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We may disclose PHI in response to a court or administrative order, subpoena, discovery request or other lawful process if certain conditions are met and the required assurances are received. We provide PHI when otherwise required by law, such as for law enforcement purposes. We may disclose your PHI to public health or the public. In other situations not described here, we will ask for your written authorization before using or disclosing your PHI.

If you choose to sign an authorization to allow disclosure of your PHI, you can later revoke that authorization to stop any future uses and disclosures (other than for treatment, payment and health care operations).



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

### **Individual Rights**

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

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

### **Complaints**

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

### **Our Legal Duty**

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

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

Customer Service  
PO Box 330  
Minneapolis, MN 55440-0330  
(651) 406-5959 or (800) 704-6993

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

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

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

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

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

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

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

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

# **DELTA DENTAL OF MINNESOTA**

## **FOR CLAIMS AND ELIGIBILITY**

P.O. Box 330  
Minneapolis, Minnesota 55440-0330  
(651) 406-5916 or (800) 553-9536

## **FOR APPEALS**

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

## **CORPORATE LOCATION**

500 Washington Avenue South  
Suite 2060  
Minneapolis, MN 55415  
(651) 406-5900 or (800) 328-1188  
[www.deltadentalmn.org](http://www.deltadentalmn.org)