Dental Benefit Plan Summary

DeltaCare
Plan Number 4
Orthodontics - $1,000 maximum

A MANAGED DENTAL CARE PROGRAM
Administered by Delta Dental of Minnesota

Dental Benefit Plan Summary

PLAN DESIGN 4
$1,000 orthodontics

This is a Summary of your Managed Care Group Dental Program (**PROGRAM**).

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ELIGIBILITY

Effective Dates of Coverage

Eligible Employees (Enrollees):

You are covered under this program when the program first became effective, or if you are a new employee of the Group Subscriber, on the date following your group's probationary period.

Eligible Dependents:

Your eligible dependents are covered under this program on the day your coverage first becomes effective up to their 26th birthday.

Covered Persons under this Program are:

Employees

a) All Eligible Employees who have met the eligibility requirements as established by the Group Subscriber and stated within this Dental Benefit Plan Summary under Effective Date of Coverage.

b) Eligible Employees of the Group Subscriber who have become totally disabled.

Dependents

a) Spouses of the Group Subscriber's Eligible Employees.

b) Dependent children of the Group Subscriber's Eligible Employees immediately from the moment of birth until the age of 26 years.

c) A dependent child of the Group Subscriber's Eligible Employees over the age of 26 years who is continuously both: (1) incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder, or physical handicap; and, (2) chiefly dependent upon an Eligible Employee or an Eligible Employee's spouse for support and maintenance provided that proof of such incapacity and dependency is furnished to Delta by the Group Subscriber within 31 days after such child obtains the age of 26 years and subsequently, as may be required by Delta, but not more frequently than annually after the period following the child's attainment of the age of 26 years. Coverage for such a dependent child over the age of 26 years will be on the same basis as coverage for other Dependents.

d) Dependent survivors of the Group Subscriber's deceased Eligible Employees who die while this Contract is in effect.

e) Adopted children. Coverage for adopted children shall be effective from the date of placement for the purpose of adoption and shall continue on the same basis as coverage for other Dependents unless the placement is disrupted prior to legal adoption and the child is removed from placement.

f) Dependent grandchildren who reside with a grandparent who is covered as an employee under this dental benefit plan.

NOTE: Except as specifically provided above, neither the amount of support provided by the employee to a dependent child nor the residency of the child will be used as an excluding or limiting factor for the child's eligibility for coverage of payment for benefits under this dental benefit plan.

Your eligible dependents, as defined above, 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 first of the month following the date you first acquire eligible dependents, or add dependent coverage subject to the open enrollment requirements of the Group Subscriber, 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.

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 Subscriber on a current basis.

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 Subscriber terminates the Program by failure to pay the required Group Subscriber payments, except as a result of inadvertent error.

NOTE: Termination of this dental benefit plan will be effective only upon Delta making a good faith effort to notify all Covered Persons of the cancellation at least 30 days before the effective cancellation date. Notice of cancellation will be sent to the home address of the Covered Person identified on the list compiled at the time application for coverage was obtained. This 30 day notice requirement will not apply upon cancellation of this dental benefit plan if it has been replaced by a substantially similar policy, plan or contract.

For extended eligibility, see Continuation of Coverage.

Continuation of Coverage

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 1
Employment ends, retirement, leave of absence, lay-off, or employee becomes ineligible (except gross misconduct dismissal)

Who May Continue: Employee and dependents, OR dependents

Maximum Continuation Period:
Earlier of:
a. 18 months or
b. Date coverage would otherwise end.

Qualifying Event 2
Divorce, marriage dissolution, or legal separation

Who May Continue: Spouse, Former Spouse and any dependent children who lose coverage

Maximum Continuation Period:
Earlier of:
a. Enrollment date in other group coverage or
b. Date coverage would otherwise end.

Qualifying Event 3
Death of Employee

Who May Continue: Surviving spouse and dependent children

Maximum Continuation Period:
Earlier of:
a. Enrollment date in other group coverage or

b. Date coverage would otherwise end if the employee had lived.

Qualifying Event 4
Dependent child loses eligibility

Who May Continue: Dependent child

Maximum Continuation Period:
Earliest of:
a. 36 months
b. Enrollment date in other group coverage or
c. Date coverage would otherwise end.

Qualifying Event 5
Employee's total disability

Who May Continue: Employee and dependents

Maximum Continuation Period:
Earliest of:
a. Date total disability ends, or
b. Date coverage would otherwise end.

Qualifying Event 6
Employee's entitlement to Medicare

Who May Continue: Spouse and dependents

Maximum Continuation Period:
a. 36 months
b. Enrollment date in other group coverage or
c. Date coverage would otherwise end.

Qualifying Event 7
Retirees of employer filing Chapter 11 bankruptcy
(includes substantial reduction in coverage within 1 year of filing)

Who May Continue: Retiree and dependents

Maximum Continuation Period:
a. Enrollment date in other group coverage or
b. Death of retiree or dependent.

Qualifying Event 8
Surviving Dependents of retiree on lifetime continuation due to the bankruptcy of the employer

Who May Continue: Surviving Spouse and dependents

Maximum Continuation Period:
a. 36 months following retiree's death, or
b. 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.

Terminating Continuation of Coverage

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

a) The expiration of the specified period of time for which Continuation of Coverage can be maintained; as mandated by applicable State or Federal law;

b) This Program is terminated by the Group Subscriber;

c) The Group Subscriber's failure to make the payment for the Covered Person's Continuation of Coverage;

d) You become eligible for Medicare benefits (refer to Continuation of Coverage for eligible dependents);

e) Any person who has elected to continue coverage becomes eligible for coverage under another dental benefit program, unless due to total disability.

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

PLAN PAYMENTS

Covered Fees

Under this Program, YOU MUST GO TO YOUR PRESELECTED DENTAL OFFICE TO BE ELIGIBLE FOR BENEFITS. COPAYMENTS ARE DUE AT THE TIME OF SERVICE.

Claims Appeal Procedure

If an Enrollee has any complaint regarding eligibility, the denial of dental services, the policies, procedures or operations of Delta, or the quality of dental services performed by a Panel Dentist, the Enrollee may call Delta or the complaint may be addressed in writing to Delta and must include (1) the name of the patient, (2) the name, address, telephone number and identification number of the Primary Enrollee, (3) the name of the Group Subscriber and (4) the Dentist's name and address. Within 10 working days of the receipt of a written complaint and the above information, Delta will forward to the complainant an acknowledgment of receipt of the complaint. Certain complaints may require that the complainant be referred to a Dentist for a clinical evaluation of the dental services provided.

Within 30 days of the receipt of the written complaint and the above information, Delta shall send to the complainant a written complaint report which describes the complaint and Delta's resolution of the complaint, or explains why additional time is required to report on the complaint. The report shall advise that a review of Delta's decision shall be undertaken if a written request, stating the reasons why the complaint should be reviewed, is made with 30 days of the date of the report. Delta shall undertake a full and fair review upon any request for review. Delta may require additional documents as it deems necessary or desirable in making such a review. Within 30 days of the request for review, Delta shall notify the complainant in writing of the results of the review, or explain why additional time is required to issue the results of the review.

The decision of Delta shall be final unless within thirty (30) days of receiving the decision the Group or the Dentist requests in writing, binding arbitration of the dispute. If the dispute involves Contract interpretation, then the arbitration shall be conducted according to the rules for commercial arbitration of the American Arbitration Association. If the dispute involves a question of acceptable standards of dentistry, then arbitration shall be conducted in a manner consistent with the commercial rules of arbitration of the American Arbitration Association except that the arbitrator or arbitrators so selected shall be licensed Dentists.

GENERAL INFORMATION

Using Your Dental Program

Upon enrollment in the Program, you will preselect a Panel Dentist. If you have any questions, please call:

Delta Dental of Minnesota - (651) 406-5903 or (800) 932-3067

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.

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

* YOUR DELTA GROUP SUBSCRIBER NUMBER
* YOUR EMPLOYER (GROUP SUBSCRIBER 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 Delta only on an anniversary date of the Group Dental Plan Contract, or at any time the Group Subscriber fails to make the required payments or meet the terms of the Contract.

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

DESCRIPTION OF COVERED SERVICES AND PERCENTAGES
Plan 4 - Schedule A

These services will be performed as needed and deemed necessary by your Panel Dentist in accordance with standard of care practices adopted by Delta management.

The dental Program pays the following percentages of treatment cost. You **MUST** go to your pre-selected dental office to be eligible for benefits. Any procedure not listed as a covered benefit is available on a fee for service basis. Care rendered by other dental providers **WILL NOT** be reimbursed.

Diagnostic & Preventive Services

Oral examinations of any type (including emergency exams and specialist exams) at six (6) month intervals, or as prescribed by the Plan Dentist.

Coverage.....100%

Bitewing x-rays: One (1) series of up to four (4) films every twelve (12) months for Covered Persons up to age eighteen (18); one (1) series of up to four (4) films every twenty-four (24) months for Covered Persons age eighteen (18) and over.

Coverage.....100%

Four (4) periapical x-rays (PAs) in any twelve (12) month interval.

Coverage.....100%

Full mouth x-rays once in any sixty (60) month interval, or as prescribed by the Plan Dentist.

Coverage.....100%

Dental or periodontal prophylaxis (cleaning of the teeth) every six (6) months, or as prescribed by the Plan Dentist.

Coverage.....100%

Topical fluoride applications once in any twelve (12) month interval and then only for Covered Persons under the age of nineteen years, or as prescribed by the Plan Dentist.

Coverage.....100%

Basic Services

Emergency treatment for relief of pain (minor procedures).

Coverage.....100%

Space maintainers for extracted posterior primary teeth on Covered Dependent Children.

Coverage.....100%

Restoration of lost tooth structure as a result of tooth decay or fracture, when restored with amalgams (silver fillings), resins (white fillings) or preformed crowns for dependent children only up to nineteen years.

Coverage.....100%

When resins (white fillings) are placed in posterior teeth, or if inlays, onlays, or three-quarter (:) crowns are placed, benefits shall be limited to the same surfaces and allowances for amalgam (silver filling).

LIMITATION: Benefit for the replacement of restorations shall be provided only after a two (2) year period has elapsed measured from the date on which the procedure was last benefited by the Plan.

Coverage.....100%

Sealants or Preventive Resin Restorations: Coverage is for permanent molars as prescribed by the Plan Dentist.

Coverage.....100%

General anesthesia or intravenous sedation will be eligible as a separate benefit in conjunction with a complex surgical service covered under Delta.

Coverage.....100%

Endodontics

Includes pulpotomies on primary teeth for dependent children and root canal therapy on permanent teeth. No coverage is provided for retreatment.

Coverage.....100%

Periodontics

Nonsurgical periodontics: procedures necessary for the treatment of the diseases of the gingiva (gums).

LIMITATION: Coverage is limited to one (1) nonsurgical periodontal treatment per quadrant every thirty-six (36) months.

Coverage.....100%

Surgical periodontics: the surgical procedures necessary for the treatment of the gingiva (gums) and bone supporting the teeth.

LIMITATION: Coverage is limited to one (1) nonsurgical periodontal treatment per quadrant every thirty-six (36) months.

Procedures designed to enable prosthetic or restorative services to be performed, such as crown lengthening, are not covered.

Coverage.....100%

Oral Surgery

Simple extractions for tooth removal.

Coverage.....100%

Surgical extractions for tooth removal, including pre- and post-operative care.

Coverage.....100%

Major Restorative Services

Special restorative procedures to restore lost tooth structure as a result of tooth decay or fracture.

Coverage.....60%

Crowns, when the amount of lost tooth structure does not enable the placement of a filling material.

LIMITATION: Benefit for the replacement of a crown will be provided only after a five (5) year period measured from the date on which the procedure was last benefited.

Coverage.....60%

Prosthetics: Removable and Fixed

Bridges, standard partial dentures and full dentures for the replacement of fully extracted permanent teeth. Benefits are limited to the commonly performed method of tooth replacement.

EXCLUSION: Coverage is NOT provided for the replacement of misplaced, lost or stolen dental prosthetic appliances.

EXCLUSION: Coverage is not provided under this dental benefit plan for the initial installation of a bridge, denture or implant to replace any tooth that was missing on the date coverage became effective for the person for whom such bridge or denture is to be installed. EXCEPTION: This exclusion will only apply for the first twenty-four (24) months of coverage under this Plan.

Coverage.....60%

Replacement benefits for Prosthetic services: a given prosthetic appliance for the purpose of replacing an existing appliance will be provided only after five (5) years have elapsed from when last benefited and then only in the event that the existing appliance is not and cannot be made satisfactory. Services which are necessary to make an appliance satisfactory will be provided.

Replacement benefits for Fixed Prosthetics: none of the individual units of the bridge may have been benefited previously as a crown or cast restoration during the last five (5) year period. The fabrication of the bridge due to the loss of an existing permanent tooth does not set aside the five (5) year exclusion on cast restorations.

EXCLUSION: Coverage is NOT provided for replacement of an existing partial denture with a bridge.

EXCLUSION: Coverage is NOT provided for the replacement of teeth congenitally missing.

Alveoloplasty and vestibuloplasty when required to prepare for dentures.

Coverage.....60%

Prosthetic Repairs and Adjustments

Prosthetics: provides for adjustments to prosthetic appliances and provides for office relines at twelve (12) month intervals. This does not include laboratory procedures.

Coverage.....60%

Emergency Coverage at Non-Plan Offices

Subject to coverage conditions contained elsewhere in this Description of Covered Services, the Plan will reimburse or pay on behalf of Covered Persons $50.00 for expenses incurred for dental services to relieve pain in emergency conditions from non-plan providers.

TMJ

Surgical and nonsurgical treatment of temporomandibular joint disorder (TMD) and craniomandibular disorder, subject to Coordination of Benefits, will be paid at 60% up to $1000.00 per Enrollee per year.

Orthodontics

Treatment necessary to move teeth for the prevention and correction of malocclusion.

LIMITATION: Coverage for orthodontic treatment for eligible dependent children is limited to their eighth birthday up to the nineteenth birthday.

EXCLUSION: Coverage is NOT provided for the repair or replacement of any orthodontic appliance (fixed or removable).

NOTE: Orthodontic retainers (fixed or removable) are ONLY benefited when included as part of the complete orthodontic treatment.

Coverage.....50%
up to a lifetime maximum of $1,000.00

EXCLUSIONS OF SERVICES
Plan 4- Schedule B

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 Workers' 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.

b) Dental procedures performed for purely cosmetic purposes.

c) Charges for dental procedures which were completed prior to the date the Covered Person became eligible for coverage under the Group Dental Plan Contract.

d) Services of anesthesiologists.

e) Charges for any dental procedures or health care services not specifically covered under the Group Dental Plan Contract (including any hospital charges or prescription drug charges). New or experimental dental techniques or procedures may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.

f) Dental procedures performed other than by a licensed Panel Dentist and his or her employees or agents.

g) Dental procedures, 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 (wear), realignment of teeth, periodontal splinting and gnathologic recordings.

h) Direct diagnostic, surgical or nonsurgical treatment procedures applied to body joints or muscles; except as provided under orthodontics or oral surgery.

i) Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.

j) No benefits shall be provided for teeth retained in relation to an overdenture, and overdenture appliances shall be limited to an allowance for standard appliances.

k) Any oral surgery which includes surgical endodontics (apicoectomy, retrograde filling) other than that listed under Oral Surgery.

l) Analgesia (nitrous oxide).

m) Removable unilateral dentures.

n) Temporary procedures.

o) Splinting.

p) Coverage is not provided under this dental benefit plan for the initial installation of a bridge, denture or implant to replace any tooth that was missing on the date coverage became effective for the person for whom such bridge or denture is to be installed. EXCEPTION: This exclusion will only apply for the first twenty-four (24) months of coverage under this Plan.

q) Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete).

r) Veneers (bonding of coverings to the teeth).

s) Orthodontic treatment procedures, unless specified in this Dental Benefit Plan Summary as a covered dental benefit.

t) Corrections of congenital conditions, other than for congenitally missing teeth.

u) Athletic mouthguards.

v) Retreatment or additional treatment necessary to correct or relieve the results of previous treatment.

w) Amalgam or composite restorations placed for preventive or cosmetic purposes.

DELTA DENTAL OF MINNESOTA

FOR CLAIMS AND ELIGIBILITY
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