PLAN DOCUMENT
AND SUMMARY PLAN DESCRIPTION
Delta Dental of Minnesota
A Component of Mayo Dental ‘Plus’ Plan

January 2018
DELTA DENTAL PPO PLUS PREMIER - COMPREHENSIVE ENHANCED
Standard and Deluxe Plans

Plan Document and Summary Plan Description

Mayo Clinic
Group Number 201003 (Standard)
Group Number 386207 (Deluxe)
INTRODUCTION

Mayo Clinic sponsors the Mayo Dental Plan. The Delta Dental plan is one component of this plan. This component of the Mayo Dental Plan will be referred to in this document as the Plan. You must enroll in the Plan in order to obtain coverage. You can enroll in only one component of the Mayo Dental Plan, and if you are enrolled in the Plan, you cannot enroll yourself or your eligible family members in a different component of the Mayo Dental Plan, such as the Mayo Reimbursement Account. References to the “Group” shall be references to Mayo Clinic as the Plan Sponsor, and any participating employer who has adopted the Plan.

Effective January 1, 2018, this document sets forth the benefits for employees who are eligible under the Plan.

Because this document is intended to give employees an easily understood explanation of the Plan, it also serves as the Summary Plan Description. Privacy rules required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are part of this Plan and are stated in a separate document that is available from the Plan Administrator and available online with the Summary Plan Descriptions. Simply go to HR Connect, Summary Plan Descriptions, and you will find the HIPAA Privacy Notices.

Benefits under the Plan are “excepted benefits” as defined in Section 732(c) of ERISA and Sections 9831(c)(1) and 9832(c)(2) of the Code.

ADMINISTRATION

The following information is provided as required by the Employee Retirement Income Security Act of 1974, as amended by ERISA.

PLAN NAME
Mayo Dental Plan

PLAN SPONSOR AND ADMINISTRATOR:
Mayo Clinic
200 First Street SW
Rochester, MN 55905
Telephone: (507) 284-9896

NAMED FIDUCIARY
Salary & Benefits Committee
Mayo Clinic
200 First Street SW
Rochester, MN 55905
(507) 266-0440

AGENT FOR SERVICE OF LEGAL PROCESS:
Mayo Clinic c/o William A. Brown, Assistance Treasurer
200 First Street SW
Rochester, MN 55905
Telephone: (507) 266-0440
The Plan Administrator may also be served with process

FUNDING: This Plan is a component of the Mayo Dental Plan and is self-funded. Your contribution towards the cost of the coverage under the Plan will be determined by the Employer each year and communicated to you prior to the effective date of any changes in the cost of the coverage.
Eligible employees pay their share of the cost of coverage elected under the Plan on a pre-tax basis for themselves, their spouses, and their children. Such pre-tax payments are permitted under Section 125 of the Internal Revenue Code, subject to certain rules and limitations, including the requirement of a written plan document. This document includes the written Pre-Tax Premium Payment Rules for the Mayo Dental Plan ("Pre-Tax Premium Rules"). The Plan will be administered in accordance with these rules and limitations and with any subsequent amendment to or clarification of the rules and limitations. The Pre-Tax Premium Rules are not subject to ERISA. The plan year for the Premium Payment Rules is the calendar year.

EMPLOYER IDENTIFICATION NUMBER: 41-6011702

EMPLOYER PLAN NUMBER: 514

DELTA DENTAL GROUP NUMBER: 201003 & 386207

CLAIMS ADMINISTRATOR:
For Claims and Eligibility
Delta Dental of Minnesota
National Dedicated Service Center
P.O. Box 59238
Minneapolis, Minnesota 55459
(651) 406-5901 or (800) 448-3815
www.deltadentalmn.org

For Appeals:
P.O. Box 551
Minneapolis, Minnesota 55440-00551

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

COMPONENTS OF MAYO DENTAL PLAN DOCUMENT
Delta Dental of Minnesota
Mayo Reimbursement Account
Retiree Mayo Reimbursement Account
Privacy Rule

DELTA DENTAL BENEFIT PLAN SUMMARY
This is a Summary of your Group Dental Program (PROGRAM) prepared for Covered Persons with:

Mayo Clinic (GROUP)

This Program has been established and is maintained and administered in accordance with the provisions of your Group Dental Plan Contract Number 201003 & 386207 issued by Delta Dental of Minnesota (PLAN).

This is the Plan Document for the Delta Dental, but because it is intended to give employees an easily understood explanation of the Plan, it also serves as the Summary Plan Description (SPD). Mayo Clinic and participating Employers are listed at the end of this document.

IMPORTANT

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

DELTA DENTAL OF MINNESOTA

Administrative Offices
Delta Dental of Minnesota
National Dedicated Service Center
P.O. Box 59238
Minneapolis, Minnesota  55459
(651) 406-5901 or (800) 448-3815
www.deltadentalmn.org
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SUMMARY OF DENTAL BENEFITS – Delta Dental Standard

Coinsurance Percentage of Coverage

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 dentists, Delta Dental Premier dentists and nonparticipating dentists. If you see a nonparticipating dentist, your out-of-pocket expenses may increase.

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<thead>
<tr>
<th>Service</th>
<th>Delta Dental PPO</th>
<th>Delta Dental Premier</th>
<th>Out-of-Network</th>
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<tr>
<td>Diagnostic and Preventive Service</td>
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<td>Basic Service</td>
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<td>Orthodontics</td>
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Benefit Maximums

The Program pays up to a maximum of $1,000.00 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.

Orthodontics is subject to a separate lifetime maximum of $1,500.00 per Covered Person and limited to those orthodontic treatment plans commenced on or after the Eligible Dependent Child’s eighth (8th) birthday.

Deductible

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

The deductible does not apply to Diagnostic and Preventive or Orthodontic services.

Coverage Year

A Coverage Year is a 12-month period in which deductibles and benefit maximums apply. Your Coverage Year is January 1 through December 31.
SUMMARY OF DENTAL BENEFITS – Delta Dental Deluxe Plan

Effective 01/01/2018 an additional dental plan offering is available. In addition to Delta Dental Standard plan, the Delta Dental Deluxe plan offers additional dental coinsurance, orthodontic coverage and annual maximum amounts. All other limitations, frequencies and exclusions apply.

Coinsurance Percentage of Coverage

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 dentists, Delta Dental Premier dentists and nonparticipating dentists. If you see a nonparticipating dentist, your out-of-pocket expenses may increase.

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Benefit Maximums

The Program pays up to a maximum of $2,000 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.

Orthodontics is subject to a separate lifetime maximum of $2,500 per Covered Person and limited to those orthodontic treatment plans commenced on or after the Eligible Dependent Child’s eighth (8th) birthday.

Effective 01/01/2018, under Delta Dental Deluxe, you may be eligible for an additional $1,000 orthodontic reimbursement if you have orthodontic work in progress. To qualify you must:

- Must still be in active orthodontic treatment (bands are in place) as of 01/01/2018 (not applicable for retention phase) and enrolled in Delta Dental Standard in 2017
- Original length of treatment has not been extended

To apply for the increase after 01/01/2018:

- Your orthodontist will need to submit a written request, including current signature, on a voucher or resubmit the original claim, in writing, indicating “Increase in benefit, please review”
• The claim will be reviewed and increase orthodontic benefit will be paid based on the treatment plan and eligible dollars that qualify

Deductible

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

The deductible does not apply to Diagnostic and Preventive or Orthodontic services.

Coverage Year

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

DESCRIPTION OF COVERED PROCEDURES

Pretreatment Estimate
(Estimate of Benefits)

It is recommended that a pretreatment estimate be submitted to the plan prior to treatment if your dental treatment involves major restorative, periodontics, prosthetics or orthodontic care (see description of coverages), to estimate the amount of payment. The pretreatment estimate is a valuable tool for both the dentist and the patient. Submission of a pretreatment estimate allows the dentist and the patient to know what benefits are available to the patient before beginning treatment. The pretreatment estimate will outline the patient’s responsibility to the dentist with regard to co-payments, deductibles and non-covered services and allows the dentist and the patient to make any necessary financial arrangements before treatment begins. This process does not prior authorize the treatment nor determine its dental or medical necessity. The estimated Delta Dental payment is based on the patient’s current eligibility and current available contract benefits. The subsequent submission of other claims, a change in eligibility, a change in the contract coverage or the existence of other coverage may alter the Delta Dental final payment amount as shown on the pretreatment estimate form.

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

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

Benefits

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

As a condition precedent to the approval of claim payments, the Plan shall be entitled to request and receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which a dentist's care is provided, such information and records relating to a Covered Person as may be required to pay claims. Also, the Plan may require that a Covered Person be examined by a dental consultant retained by the Plan in or near the Covered Person's place of residence. The Plan shall hold such information and records confidential.
To avoid any misunderstanding of benefit payment amounts, ask your dentist about his or her network participation status within your Delta Dental PPO and Delta Dental Premier networks prior to receiving dental care.

Delta Dental of Minnesota does not determine whether a service submitted for payment or benefit under this Plan is a dental procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. Delta Dental of Minnesota evaluates dental procedures submitted to determine if the procedure is a covered benefit under your dental plan. Your dental Plan includes a preset schedule of dental services that are eligible for benefit by the Plan. Other dental services may be recommended or prescribed by your dentist, which are dentally necessary, offer you an enhanced cosmetic appearance, or are more frequent than covered by the Plan. While these services may be prescribed by your dentist and are dentally necessary for you, they may not be a dental service that is benefited by this Plan or they may be a service where the Plan provides a payment allowance for a service that is considered to be optional treatment. If the Plan gives you a payment allowance for optional treatment that is covered by the plan, you may apply this Plan payment to the service prescribed by your dentist which you elected to receive. Services that are not covered by the Plan or exceed the frequency of Plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for dental services that are not covered or benefited by the Plan. Determination of services necessary to meet your individual dental needs is between you and your dentist.

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

PREVENTIVE CARE
(Diagnostic & Preventive Services)

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

NOTE: Comprehensive oral evaluations will be benefited 1 time per dental office, subject to the 2 times calendar year 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 2 times per calendar year period.

Radiographs (X-rays)

- **Bitewings** - Covered at 2 series of films per calendar year period.
- **Full Mouth (Complete Series) or Panoramic** - Covered 1 time per 36-month period.
- **Periapical(s)** - 4 single X-rays are covered per 12-month period.
- **Occlusal** - Covered at 1 series per 12-month period.

Dental Cleaning

- **Prophylaxis** - Covered 2 times per calendar year 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** - Covered 2 times per calendar year period.

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

**Fluoride Treatment** (Topical application of fluoride) - Covered 2 times per calendar year period for dependent children through the age of 17.

**Space Maintainers** - Covered 1 time per lifetime on eligible dependent children through the age of 13 for extracted primary posterior (back) teeth.

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

**Full mouth debridement** - Covered 1 time per 24 month period.

**BASIC SERVICES**

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

  Benefits shall be limited to the same surfaces and allowances for amalgam (silver filling). The patient must pay the difference in cost between the Plan’s Payment Obligation for the covered benefit and the dentist’s submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

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

**Other Basic Services**

- **Restorative cast post and core build-up, including pins and posts** - See benefit coverage description under Complex or Major Restorative Services.

- **Pre-fabricated or Stainless Steel Crown** - Covered 1 time per 24-month period for eligible dependent children through the age of 18.

- **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 17.

**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. Amalgam or composite restorations placed for preventive or cosmetic purposes.

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

**Endodontic Therapy on Primary Teeth**
- **Pulpal Therapy** - Covered 1 time per tooth per lifetime.
- **Therapeutic Pulpotomy** - Covered 1 time per tooth per lifetime.

**Endodontic Therapy on Permanent Teeth**
- **Root Canal Therapy** - Covered 1 time per 36-month period.
- **Apicoectomy** - Covered 1 time per tooth per lifetime.
- **Root Amputation on posterior (back) teeth** - Covered 1 time per tooth per lifetime.

**Complex or other Endodontic Services**
- **Apexification** - Covered 1 time per 36-month period for dependent children through the age of 16.
- **Retrograde filling** - Covered 1 time per 36-month period.
- **Hemisection, includes root removal** - Covered 1 time per tooth per lifetime.

**EXCLUSIONS - Coverage is NOT provided for:**
1. Retreatment of endodontic services that have been previously benefited under the Plan.
2. Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
3. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
4. Intentional reimplantation.

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**PERIODONTICS (GUM & BONE TREATMENT)**

**Basic Non Surgical Periodontal Care** - Treatment for diseases for the gingival (gums) and bone supporting the teeth.
- **Periodontal scaling & root planing** - Covered 1 time per 24 months.
Complex Surgical Periodontal Care - Surgical treatment for diseases for the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this plan.

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

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

Crown lengthening

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

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

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

**Basic Extractions**

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

**Complex Surgical Extractions**

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

**Other Complex Surgical Procedures**

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

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

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

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

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

**LIMITATIONS**

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

2. Inpatient or outpatient dental expenses arising from dental treatment up to age 18, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate as required by Minnesota Statute section 62A.042.

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

   **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.

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

1. Intravenous conscious sedation and IV sedation when performed with non-surgical dental care.

2. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration.
3. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.

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

5. Surgical exposure of impacted or unerupted tooth for orthodontic reasons.


7. Inpatient or outpatient hospital expenses.


**COMPLEX OR MAJOR RESTORATIVE SERVICES**

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

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

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

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

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

**Implant Crowns** - See Prosthetic Services.

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

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

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

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

1. Procedures designed to enable prosthetic or restorative services to be performed.

2. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

3. 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.

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

5. Temporary, provisional or interim crown.

6. Occlusal procedures including occlusal guard and adjustments.
PROSTHETIC SERVICES (DENTURES, PARTIALS, AND BRIDGES)

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) - Covered when:
- the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Reline, Rebase - Covered 1 time per 24-month period:
- the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Adjustments - Covered 2 times per 12-month period:
- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Removable Prosthetic Services (Dentures and Partials) - Covered 1 time per 5-year period:
- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) - Covered 1 time per 5-year period:
- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last 5 years;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing appliance needs replacement because it cannot be repaired or adjusted.

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

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

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

EXCLUSIONS - Coverage is NOT provided for:
1. The replacement of an existing partial denture with a bridge.
2. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
3. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
4. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.

5. Procedures designed to enable prosthetic or restorative services to be performed.

6. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

7. Services or supplies that have the primary purpose of improving the appearance of your teeth.

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

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

10. Coverage shall be limited to the least expensive professionally acceptable treatment.

**ORTHODONTICS**

Treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies.

**Limited Treatment**

Treatments which are not full treatment cases and are usually done for minor tooth movement.

**Interceptive Treatment**

A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.

**Comprehensive (complete) Treatment**

Full treatment includes all records, appliances and visits.

**Removable Appliance Therapy** - An appliance that is removable and not cemented or bonded to the teeth.

**Fixed Appliance Therapy** - A component that is cemented or bonded to the teeth.

**Other Complex Surgical Procedures**

- Surgical exposure of impacted or unerupted tooth for orthodontic reasons
- Surgical repositioning of teeth

**LIMITATION:** Treatment in progress (appliances placed prior to eligibility under this Plan) will be benefited on a pro-rated basis.

**LIMITATION:** Covered eligible dependent children from the age of 8.

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

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service;
4. Retreatment and/or services for any treatment due to relapse;
5. Inpatient or outpatient hospital expenses; and
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

**Orthodontic Payments:** Available benefit payment is made in a single payment amount, for orthodontic treatments beginning January 1, 2015 and after. Treatment begins when appliances are installed.

Before treatment begins, the treating dentist should submit a Pre-treatment Estimate request. An Estimate of Benefits form will be sent to you and your dentist indicating the estimated plan payment.
amount. This form serves as a claim form to submit when treatment begins. When treatment begins, the dentist should submit the Estimate of Benefit form with the date of placement and his/her signature. After benefit and eligibility verification by the Plan, the single benefit payment will be issued.

**Exclusions**
Coverage is NOT provided for:

a) Dental services which aCovered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving Medical Assistance pursuant to Minnesota Statute Section 62A.045.

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

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

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

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

f) Services of anesthesiologists.

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

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

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

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

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

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

m) Orthodontic treatment services, unless specified in this Delta Dental Benefit Plan Summary as a covered dental service benefit.

n) Case presentations, office visits and consultations.

o) Incomplete, interim or temporary services.

p) Athletic mouth guards, enamel microabrasion and odontoplasty.

q) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.

r) Procedures designed to enable prosthetic or restorative services to be performed.
s) Bacteriologic tests.

t) Cytology sample collection.

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

v) Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).

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

x) The replacement of an existing partial denture with a bridge.

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

z) Provisional splinting, temporary procedures or interim stabilization.

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

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

cc) Occlusal procedures including occlusal guard and adjustments.

dd) Oral hygiene instructions

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

**Limitations**

a) 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.

For other dental procedure exclusions and limitations, refer to the Description of Coverages in this Delta 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

Covered Persons under this Program are:

Employee

If you are classified by a participating employer for payroll and personnel purposes as an employee who is regularly scheduled to work at least 40 hours or more per pay period for the employer, you are considered an eligible employee and eligible to enroll for single or family coverage on the first day of employment and during the annual open enrollment. Regularly scheduled means your schedule on file with your employer is .5 FTE or more. A .4 FTE working extra hours does not qualify as regularly scheduled to work .5 FTE. Eligible Family Members are described below.

An employer’s classification is conclusive and binding for purposes of determining benefit eligibility under the Plan. No reclassification of an employee’s or non-employee’s status for any reason by a third party, whether by a court, governmental agency, or otherwise, and without regard to whether or not the employer agrees to the reclassification, shall make the employee retroactively or prospectively eligible for benefits. Any uncertainty regarding an employee’s classification will be resolved by excluding that person from eligibility.

All employees who are eligible for coverage under the plan are also eligible to participate in the Pre-Tax Premium Rules. Any Employee who elects dental coverage under this plan will automatically pay his or her share of the cost of such coverage through the Pre-Tax Premium Payment Rules.

NOTE: If both you and your spouse are employees of the employer, you may be covered as either an employee or as an eligible family member, but not both. Your eligible family members may be covered under either parent’s coverage, but not both.

Eligible Family Members

Eligible family members include your spouse and your child or children who are under the age of 26, even if they are eligible for dental coverage through another plan. A child or children include an employee’s biological children, stepchildren, legally adopted children, or children legally placed with you for adoption.

A child who is physically or mentally incapable of self-support at age 26 and beyond may continue coverage under the Plan. Effective January 1, 2014, new hires and newly benefit-eligible employees will require proof of disability as defined by Social Security Disability Insurance (SSDI) for children who are age 26 or older. The employee must provide proof that the child has been declared disabled and is receiving SSDI prior to age 26. Coverage will end if your own coverage ends or if the Child marries or is no longer incapacitated.

A child whose coverage is required under a Qualifying Medical Child Support Order (QMCSO) will be eligible to participate in the Plan. The Plan Administrator will review a child support order and determine whether it is qualified. Upon written request to the Plan Administrator, you may obtain a copy of the procedures governing QMCSOs at no charge.

Effective Dates of Coverage

Eligible Employee:

You are eligible to be covered under this program when the program first became effective, January 1, 2011, or if you are a new employee of the group, on your date of hire.

Eligible Family Members:

Your eligible family members, as defined, are covered under this program:

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

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

Children may be added to the program at the time the eligible employee originally becomes effective or may be added anytime up to 30 days following the child’s 3rd birthday. If a child is born or adopted after the employee’s original effective date, such child may be added anytime between birth (or date of adoption) and 30 days following the child’s 3rd birthday. In the event that the child is not added by 30 days following their 3rd birthday, that child may be added only if there is a family status change or at the next open enrollment period, if any.

The eligibility of all covered persons, for the purposes of receiving benefits under the program, shall, at all times, be contingent upon the applicable monthly payment having been made for such covered person by the group on a current basis.

Open Enrollment

The Open Enrollment under this contract shall be held annually.

Family Status Change

Your benefit elections are intended to remain the same for the entire coverage year. During the coverage year, you will be allowed to change your benefits only if you experience an eligible family status change which includes:

- Change in legal marital status such as marriage or divorce.
- Change in number of dependents in the event of birth, adoption, or death.
- Change in your or your spouse’s employment - either starting or losing a job.
- Change in your or your spouse’s work schedule, such as going from full-time to part-time or part-time to full-time, or beginning or ending an unpaid leave of absence.
- Change in dependent status, if a child reaches maximum age under the plan.
- Change in residence or work location so you are no longer eligible for your current health plan.
- Become eligible for Medicare, Medicaid or Children’s Health Insurance Program (CHIP) coverage.
- Termination of Medicare, Medicaid or Children’s Health Insurance Program (CHIP) coverage because you or your dependents are no longer eligible.
- 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 above eligible family status changes during the year, you have 31 days (except in the case of qualification for or termination of employment assistance under Medicaid/CHIP, in which case the employee has 60 days after the date of eligibility) from the event to change your elections. If you do not change your benefits within 31 days of the event, you will not be allowed to make changes until the next open enrollment period. When you experience a family status you must contact your employer. All changes are effective the date of the change.

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

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

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

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

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

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

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

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

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

**How do I pay for my share of the cost of coverage I elect?**

All employees electing coverage under the plan pay their share of the cost of coverage through pre-tax salary reductions. This reduces taxable income reported by Mayo on your W-2. Therefore if you elect coverage under the plan, you will pay your share through pre-tax salary reductions each payroll. Your taxable compensation from Mayo will be correspondingly reduced by your share of the cost of the coverage for the benefit option and coverage level you elect. Because you pay your share of the cost of coverage pre-tax, however, federal law limits the circumstances under which you can make changes to your pre-tax election during the plan year. Unless you have a special enrollment or change in status event (as discussed above) you will not be able to make changes until the next open enrollment period.

**When Can I Make Mid-Year Changes to my Coverage Election?**

You can only change your coverage election under the plan if you have either a special enrollment event or change in status event as discussed in this sub-section. If your cost of coverage changes as a result of your permitted coverage change, Mayo will automatically increase or decrease your cost of coverage, as applicable, on the next payroll after your election change is approved.
Termination of Coverage

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

a) The end of the month in which (1) you cease to be eligible; (2) your dependent is no longer eligible as a dependent under the program.

b) On the date the program is terminated.

c) On the date the group terminates the program by failure to pay the required group subscriber payments, except as a result of inadvertent error.

For extended eligibility, see Continuation of Coverage.

If I die while still employed, what happens to coverage for family members covered under the Plan at my death?

If your spouse and eligible family members were enrolled in the plan at the time of your death, plan coverage for your eligible family members will continue until they no longer meet the definition of eligible family member. Coverage for your spouse will continue until your spouse is gainfully employed, remarried, or age 65. Coverage will not be available for any spouse or eligible dependent not enrolled at the time of your death. A spouse and other eligible family members covered under this provision will not be eligible to participate in annual open enrollment.

If your spouse is eligible for coverage as an employee under the plan, contact HR Connect for enrollment details.

NOTE: Mayo has reserved the right to amend the terms of any component of the Mayo Dental ‘PLUS’ Plan, including the MRA described herein, in any respect, at any time, and for any reason, including provisions of coverage for surviving spouses and eligible dependents. See the subsection Amendment and Termination of the plan in the Plan Administration section for additional information.

Amendment and Termination of Plan

Mayo Clinic reserves the right to amend or terminate the Plan, or any benefit option described in any document for the Mayo Dental Plan including this document at any time, for any reason, and in any respect. Mayo Clinic’s right to amend or terminate the Plan or benefit options includes, but is not limited to, changes in the eligibility requirements, employee and employer contributions, reducing or eliminating account balances, benefits provided, and termination of all or a portion of any coverage(s) provided under the Plan. If the plan or any benefit option is amended or terminated, you will be subject to all the changes effective as a result of such amendment or termination, and your rights will be reduced, terminated, altered, or increased accordingly, as of the effective date of the amendment or termination. You do not have ongoing rights to any plan or program benefit, other than payment of any covered expenses you incurred prior to the Plan amendment or termination.

Continuation of Coverage (COBRA)

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

<table>
<thead>
<tr>
<th>QUALIFYING EVENT</th>
<th>WHO MAY CONTINUE</th>
<th>MAXIMUM CONTINUATION PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment ends, retirement, lay-off, or employee becomes ineligible (except gross misconduct dismissal)</td>
<td>Employee and dependents</td>
<td>Earliest of:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. 18 months, or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Enrollment in other group coverage or Medicare, or</td>
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<td></td>
<td></td>
<td>3. Date coverage would otherwise end.</td>
</tr>
<tr>
<td>Divorce, marriage dissolution, or legal separation</td>
<td>Former Spouse and any dependent children who lose</td>
<td>Earliest of:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. 36 months or</td>
</tr>
<tr>
<td>Event</td>
<td>Eligibility</td>
<td>Earliest of:</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Death of Employee</td>
<td>Surviving spouse and dependent children</td>
<td>1. 36 months or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.</td>
</tr>
<tr>
<td>Dependent child loses eligibility</td>
<td>Dependent child</td>
<td>1. 36 months, 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.</td>
</tr>
<tr>
<td>Dependants lose eligibility due to Employee’s entitlement to Medicare</td>
<td>Spouse and dependents</td>
<td>1. 36 months, 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.</td>
</tr>
<tr>
<td>Employee’s total disability</td>
<td>Employee and dependents</td>
<td>1. 29 months or 2. Date total disability ends or 3. Enrollment date in other group coverage or Medicare.</td>
</tr>
<tr>
<td>Retirees of employer filing Chapter 11 bankruptcy</td>
<td>Retiree and dependents</td>
<td>1. Enrollment date in other group coverage, or 2. Death of retiree or dependent electing COBRA.</td>
</tr>
<tr>
<td>Surviving Dependents of retiree on lifetime continuation due to the bankruptcy of the employer</td>
<td>Surviving Spouse and dependents</td>
<td>1. 36 months following retiree’s death, or 2. Enrollment date in other group coverage.</td>
</tr>
</tbody>
</table>

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.

1. **Choosing Continuation**

   If you lose coverage, your employer must notify you of the option to continue coverage within 14 days after employment ends. If coverage for your dependent ends because of divorce, legal separation, or any other change in dependent status, you or your covered dependents must notify your employer within 60 days.

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

Charges for continuation are the entire cost of COBRA (including both employer and employee contributions) rate plus a two percent administration fee. All charges are paid directly to the COBRA administrator (assigned by your employer). If you or your covered dependents are totally disabled, charges for continuation are the entire cost of COBRA (including both employer and employee contributions) rate plus a two percent administration fee for the first 18 months. For months 19 through 29, the employer or COBRA administrator may charge the entire cost of COBRA rate plus a 50 percent administration fee.

2. Second qualifying event

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

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

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

3. Terminating Continuation of Coverage - COBRA

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

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

b) This Program is terminated by the Group Subscriber;

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

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

COBRA Administration
Discovery Benefits, Inc.
PO Box 2079
Omaha, NE 68108-2079
1-866-451-3399
M-F, 7 a.m.-7 p.m. CT (excluding holidays)
PLAN PAYMENTS

Participating Dentist Network

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

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

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

Covered Fees

Under this Program, you are free to go to the dentist of your choice. You may have additional out-of-pocket costs if your dentist is not a Delta Dental PPO or Delta Dental Premier dentist with the plan. There may also be a difference in the payment amount if your dentist is not a participating dentist with Delta 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.

Claim Payments

Payments are made by the plan only when the covered dental procedures have been completed. The plan may require additional information from you or your provider before a claim can be considered complete and ready for processing. In order to properly process a claim, the plan may be required to add an administrative policy line to the claim. Duplicate claims previously processed will be denied.

Any benefits payable under this plan are not assignable by any covered person or any eligible dependent of any covered person.

Delta Dental Premier Dentists:

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

Delta Dental PPO Dentists:

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

Nonparticipating Dentists:

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

The covered person is responsible for all treatment charges made by the nonparticipating dentist. When services are obtained from a nonparticipating provider, any benefits payable under the group contract are paid directly to the covered person.

Coordination of Benefits (COB)

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

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

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

Allocation of Responsibilities

The Named Fiduciaries may designate other persons who are not Named Fiduciaries to carry out such fiduciary responsibilities. The responsibilities imposed by the Plan on each Named Fiduciary are not joint responsibilities with any other fiduciary unless specifically so designated therein. No fiduciary is responsible for the act, or failure to act, of any other fiduciary.

Assignment of Benefits

Your right to receive benefits under the Plan is personal to you and may not be assigned or be subject to anticipation, garnishment, attachment, execution, or levy of any kind, or be liable for your debts or obligations.

Any benefits which may be payable under this dental benefit Plan are not assignable.
Claim and Appeal Procedures

Initial Claim Determinations
All claims should be submitted within 12 months of the date of service. An initial benefit determination on your claim will be made within 30 days after receipt of your claim. You will receive written notification of this benefit determination. The 30-day period may be extended for an additional 15 days if the claim determination is delayed for reasons beyond our control. In that case, we will notify you prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which we expect to render a decision. If the extension is necessary to obtain additional information from you, the notice will describe the specific information we need, and you will have 45 days from the receipt of the notice to provide the information. Without complete information, your claim will be denied.

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

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

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

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

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

To the extent your plan is covered by ERISA, after you have exhausted all appeals, you may file a civil action under section 502(a) of ERISA.

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

If you file your initial claim within the required time, and the Claim Administrator and Plan Review Committee deny your claim and appeal, you may sue over your claim (unless you have executed a release on your claim). You must, however, commence the suit within three years from the time your initial claim was submitted.

Exhaustion of Administrative Remedies

Before commencing legal action to recover benefits or to enforce or clarify rights, you must exhaust the claim and review procedures for this Plan. You are not required to file a voluntary appeal in order to exhaust the Plan claim and review procedures.

GENERAL INFORMATION

Health Plan Issuer Involvement

The benefits under the Plan are not guaranteed by Delta Dental under the Contract. As Claims Administrator, Delta Dental pays or denies claims on behalf of the Plan and reviews requests for review of claims as described in the Claim and Appeals Procedures section.

Privacy Notice

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

HIPAA Privacy Rules

Effective April 14, 2003, the Plan was subject to new federal privacy requirements. As a participant, you will receive a Notice of Privacy describing your rights under these regulations. The privacy requirements are contained in a separate document entitled “HIPAA Provisions to Mayo Clinic Group Health Plans,” which is a component of the Plan document. The privacy provisions permit Mayo, as Plan Sponsor, to obtain your protected health information for certain limited purposes, such as operation of the Plan. However, these provisions require Mayo to agree to various safeguards to protect your health information from impermissible uses and disclosures. You may obtain a copy of the privacy provisions by contacting the Plan Administrator.

How to Find a Participating Dentist

A real-time listing of participating dentists is available in an interactive directory at the Plan's user friendly web site, www.deltadentalmn.org. The Plan highly recommends use of the web site for the most accurate network information. Go to 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 Web site also allows you to print out a map directing you to the dental office you select. The Dentist Search is an accurate and up-to-date way to obtain information on participating dentists.

To search for and verify the status of participating providers, select “Dentist Search” on the www.deltadentalmn.org home page. Select the Product or Network in the drop-down menu, and search by city and state, zip code or provider or clinic name. If your dentist does not participate in the network, you may continue to use that dentist, although you will share more of the cost of your care and could be responsible for dental charges up to the dentist’s full billed amount.
If you do not have Internet access, other options are available to find a network dentist or verify that your current dentist is in the network.

- When you call to make a dental appointment, always verify the dentist is a participating dentist. **Be sure to specifically state that your employer is providing the Dental program.**

- Contact our Customer Service Center at: (651) 406-5901 or (800) 448-3815. Customer Service hours are 7 a.m. to 7 p.m., Monday through Friday, Central Standard Time.

**Using Your Dental Program**

Dentists who participate with Delta 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:

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

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

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

**EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)**

**Plan Administration**

The Plan Administrator, who is listed on the inside front cover of this brochure, is a named fiduciary under the Program and shall be responsible for the management and control of this Program. The Pre-Tax Premium Rules are not subject to ERISA.

The Plan Administrator will have the powers and duties of general administration of the Plan including the following:

a) The discretion to determine all factual and legal questions relating to the eligibility of individuals to participate or for you to remain a participant and receive benefits under the Plan.

b) To require any person to furnish such reasonable information as the Plan Administrator may request for proper administration of the Plan as a condition of eligibility for you or eligible dependents to participate and receive any benefits under the Plan.

c) To delegate to other persons authority to carry out any duty or power which under the terms of the Plan or applicable law would otherwise be a responsibility of the Plan Administrator.

d) To maintain, or to delegate to others the duty of maintaining, all necessary records for the administration of the Plan.

e) To interpret the provisions of the Plan, make and publish such rules and procedures for regulation of the Plan, and prescribe such forms as the Plan Administrator deems necessary.
The Plan Administrator is responsible for determining the level of benefits for the Program as described in this brochure. The Plan Administrator reserves the power at any and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the code or ERISA) to modify or amend, in whole or in part, any or all provisions of the Plan, provided, however, that no modification or amendment shall divest an employee of a right to those benefits to which he or she has become entitled under the Plan.

Funding Policy and Payment

The funding policy and method requires that the Group Subscriber submit payments on a monthly basis.

Procedure to Request Information

If you have any questions about this Program, contact the Plan Administrator who is listed in the inside front cover of this brochure.

Statement of ERISA Rights

As a participant in the Program, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine without charge at the Plan Administrator's office and at other specified locations such as work sites and union halls, all Plan documents, including insurance contracts, and copies of all documents such as detailed annual reports and Plan descriptions filed by the Plan with the U.S. Department of Labor.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Group, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your right, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If it finds your claim is frivolous, you will be responsible for these costs and fees. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W, Washington, D.C. 20210.
NON-DISCRIMINATION NOTICE

Discrimination is Against the Law

The Mayo Medical Plan, Mayo Flexible Spending Account Plan, Mayo Dental Plan, Mayo Retiree HRA Plan, and Mayo Clinic Employee Assistance Plan, (collectively, the Plans) comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plans do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plans provide:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as: qualified interpreters or information written in other languages.

If you need these services, contact Mayo Clinic, Chair-Total Rewards. If you believe that the Plans have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Mayo Clinic, Chair-Total Rewards 200 First Street SW Rochester, MN 55905, 507-266-0440 or fax-507-538-1856.

You can file a grievance in person, by mail, or fax. If you need help filing a grievance, Mayo Clinic, Chair-Total Rewards is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html


注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-507-266-0440（TTY：507-266-0440）（TTY：1-800-407-2442）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 507-266-0440 （телетайп: 1-800-407-2442）.

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 предмет значення, якщо ви зрозумілися на ньому, стація відповідних фігу рицарів або здатність вільного перекладу. Прошу, зв'яжіться з нами по номеру 507-266-0440 (TTY: 1-800-407-2442).


注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。507-266-0440（TTY:1-800-407-2442）まで、お電話にてご連絡ください。


Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 507-266-0440 (TTY: 1-800-402-2442)
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<td>Mayo Clinic</td>
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<td>Mayo Clinic Arizona</td>
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DELTA DENTAL OF MINNESOTA

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

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

CORPORATE LOCATION
500 Washington Avenue South
Suite 2060
Minneapolis, MN 55415
(651) 406-5900 or (800) 328-1188
www.deltadentalmn.org

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