DELTA DENTAL PPO PLUS PREMIER - COMPREHENSIVE ENHANCED
Dental Benefits
with Orthodontic Coverage

Dental Benefit Plan Summary

Pipe Trades Services MN Welfare Fund
Group Number 50865

Pipe Trades Services MN
Welfare Plan
Dental Benefits

For Plumbers and Pipefitters
in the following
United Association Local Unions

Minneapolis & St. Cloud Plumbers Local #15
St. Paul & Mankato Plumbers Local #34
St. Paul & Mankato Pipefitters Local #455
Minneapolis & St. Cloud Pipefitters Local #539
Rochester Plumbers & Pipefitters Local #6

Welfare Fund Office

Pipe Trades Services MN Welfare Fund
700 Transfer Road
St. Paul MN 55114 -1420

Telephone: (651) 645-4540
Toll Free: 1(800) 515-2818
Fax: (651) 645-8119
Web site: www.ptsmn.org
e-mail: questions@ptsmnpt.org

Board of Trustees
Pipe Trades Services MN Welfare Fund
700 Transfer Road
St. Paul, Minnesota 55114
Telephone: (651) 645-4540

The Trustees of this Plan are:

Employer Trustees

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Schulties Plumbing
1521 94th Ln NE,
Minneapolis, MN 55449

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Major Mechanical
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Maple Grove, MN 55369

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St. Paul, MN 55114

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St. Paul MN 55102

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Pipefitters Local No. 455
700 Transfer Rd
St. Paul, MN 55114

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Pipefitters Local No. 539
312 Central Ave Rm. 408
Minneapolis, MN 55414

IMPORTANT INFORMATION ABOUT THE WELFARE PLAN

The following information is provided to help you identify this Plan and the people who are involved in its operation;

1. **Name of Plan.** This Plan is known as the Pipe Trades Services MN Welfare Plan.

2. **Board of Trustees.** A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of an equal number of Association and Union representatives, selected by the Associations and Local Unions who have entered into working agreements which relate to this Plan. These working agreements are described in Item 6, which follows. If you wish to contact the Board of Trustees, you may use the address and telephone number below:

3. **Plan Sponsor and Administrator.** The Board of Trustees is both the Plan Sponsor and Plan Administrator.

4. **Identification Numbers.** The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The number assigned to the Board of Trustees by the Internal Revenue Service is 41-0761972.

5. **Agent for Service of Legal Process.** The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Board of Trustees at the Welfare Fund Office or upon any individual Trustee. Note that arbitration is available instead of a court action.

ADMINISTRATION

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

PLAN SPONSOR, FIDUCIARY AND ADMINISTRATOR:
Pipe Trades Services MN Welfare Fund
700 Tranfer Road
St. Paul, MN 55114
Telephone: (651) 645-4540

AGENT FOR SERVICE OF LEGAL PROCESS:
Pipe Trades Services MN Welfare Fund
700 Tranfer Road
St. Paul, MN 55114
Telephone: (651) 645-4540

FUNDING: This Plan is self-funded. Your contribution towards the cost of the coverage under the Plan will be determined by the Pipe Trades Services MN Welfare Plan each year and communicated to you prior to the effective date of any changes in the cost of the coverage.

Welfare Fund IDENTIFICATION NUMBER: 41-0761972

Welfare Fund PLAN NUMBER: 501

DELTA GROUP NUMBER: 50865

PLAN BENEFITS ADMINISTERED BY:
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

Please Contact Delta Dental

If you have questions regarding your coverage or payment of your claims, etc.

PLAN BENEFITS ADMINISTERED BY:
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

DENTAL BENEFIT PLAN SUMMARY

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

Pipe Trades Services MN Welfare Fund
(**GROUP**)

This Program has been established and is maintained and administered in accordance with the provisions of your Group Dental Plan Contract Number **50865** issued by Delta Dental of Minnesota (**PLAN**).

IMPORTANT

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

DELTA DENTAL OF MINNESOTA

Administrative Offices
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

TABLE OF CONTENTS

SUMMARY OF DENTAL BENEFITS 1

Copayment Percentage of Coverage 1
Maximums 1
Coverage Year 1

DESCRIPTION OF COVERED PROCEDURES 2

Pretreatment Estimate 2
Benefits 2
Exclusions 10
Post Payment Review 13

ELIGIBILITY 13

PLAN PAYMENTS 13

Participating Dentist Network 13
Covered Fees 14
Claim Payments 14
Coordination of Benefits (COB) 15
Assignment of Benefits 15
Claim and Appeal Procedures 15

GENERAL INFORMATION 16

Health Plan Issuer Involvement 16
Privacy Notice 16
How to Find a Participating Dentist 16
Using Your Dental Program 17
Cancellation and Renewal 17

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) 18

Plan Administration 18
Funding Policy and Payment 18
Procedure to Request Information 18
Statement of ERISA Rights 18

SUMMARY OF DENTAL BENEFITS

Your dental program pays the following percentages of the treatment cost, up to a maximum fee per procedure. The maximum fee allowed by Delta is different for Delta Dental PPO dentists, participating dentists and nonparticipating dentists. If you see a nonparticipating dentist, your out-of-pocket expenses may increase. If a Delta Dental PPO dentist provides dental services, the payment percentages may increase, resulting in lower out-of-pocket costs.

	Delta Dental PPO	Delta Dental Premier
Diagnostic and Preventive Service	100%	100%
Basic Service	100%	100%
Endodontics	60%	60%
Periodontics	60%	60%
Oral Surgery	60%	60%
Major Restorative Services	80%	80%
Prosthetic Repairs and Adjustments	60%	60%
Prosthetics	60%	60%
Orthodontics	100%	100%

Benefit Maximums

The Program pays up to a maximum of $2,500.00 for each Covered Person per Coverage Year subject to the coverage percentages identified above. Benefit Maximums may not be carried over to future coverage years.

> Exclusion – The benefit maximum does not apply to Diagnostic & Preventive services, for eligible dependent children up to age 18.

Orthodontics is subject to a separate lifetime maximum of $2,000.00 per Covered Person.

Deductible

There is no deductible applicable under this Plan.

Coverage Year

A Coverage Year is a 12-month period in which benefit maximums apply. Your Coverage Year is January 1 to 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 - Covered 2 times per calendar year period.

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

Comprehensive Periodontal Evaluation - Covered 2 times per calendar year period.

Radiographs (X-rays)

- **Bitewings** - Covered at 2 series of bitewings per calendar year period.
- **Full Mouth (Complete Series) or Panoramic** - Covered 1 time per 36-month period.
- **Periapical(s)** - Single X-rays.
- **Occlusal**
- **Extraoral**

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.

Space Maintainers

Sealants or Preventive Resin Restorations

Pulp Vitality Test

Diagnostic Cast

EXCLUSIONS - Coverage is NOT provided for:

1. Oral Hygiene Instructions.
2. Accession of tissue - Please submit to your Medical Plan.

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** - This service is not covered under Basic Services. Refer to the Complex or Major Restorative Services section of your benefits.

Other Basic Services

- **Restorative cast post and core build-up, including pins and posts** - See benefit coverage description under Complex or Major Restorative Services.
- **Crown pin retention** - Per tooth in addition to restoration.
- **Pre-fabricated or Stainless Steel Crown**
- **Composite Resin Crown** - Full resin - based composite coverage of tooth.
- **Sedative Fillings**
- **Office visits and consultations**
- **Therapeutic drug injections**
- **Treatment of complications (post surgical)**

Adjunctive General Services

- **Intravenous Conscious Sedation, Non-Intravenous Conscious Sedation, Anagesia, Anxiolysis Nitrous Oxide, and IV Sedation** - Covered when performed in conjunction with covered services.

EXCLUSIONS - Coverage is NOT provided for:

1. Deep sedation/general anesthesia, analgesia, analgesic agents, medicines, or drugs for non-surgical or surgical dental care, when done alone or in conjunction with a non-covered service.
2. Case presentation
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. Amalgam or composite restorations placed for preventive or cosmetic purposes.

BASIC ENDODONTIC SERVICES (NERVE OR PULP TREATMENT)

Endodontic Therapy on Primary Teeth

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

Endodontic Therapy on Permanent Teeth

- **Root Canal Therapy**

Complex or other Endodontic Services

- **Apexification**
- **Retrograde filling**

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.
5. Apicoectomy/Periradicular Services - Please submit to your Medical Plan.
6. Root Amputation - Please submit to your Medical Plan.
7. Hemisection, includes root removal - Please submit to your Medical Plan.
8. Surgical procedure for isolation of tooth with rubber dam - Please submit to your Medical Plan.

PERIODONTICS (GUM & BONE TREATMENT)

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

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

Intravenous Conscious Sedation, Non-Intravenous Conscious Sedation, Anagesia, Anxiolysis Nitrous Oxide, and IV Sedation - Covered when performed in conjunction with covered services.

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Bacteriologic tests for determination of periodontal disease or pathologic agents.
3. The controlled release of biologic materials used to aid in soft tissue and osseous tissue regeneration - Please submit to your Medical Plan.

4. Provisional splinting, temporary procedures or interim stabilization of teeth.
6. Deep sedation/general anesthesia, analgesia, analgesic agents, medicines, or drugs for non-surgical or surgical periodontal care, when done alone or in conjunction with a non-covered service.
7. Complex Surgical Periodontal Care - Surgical treatment for diseases for the gingival (gums) and bone supporting the teeth - Please submit to your Medical Plan.
8. Bone replacement graft - Please submit to your Medical Plan.
9. Guided tissue regeneration - Please submit to your Medical Plan.
10. Soft tissue allograft - Please submit to your Medical Plan.

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

EXCLUSIONS - Coverage is NOT provided for:

1. Intravenous conscious sedation and IV sedation when performed alone or in conjunction with a non-covered service.
2. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital - Please submit to your Medical Plan.
3. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
4. Surgical exposure of impacted or unerupted tooth for orthodontic reasons - Please submit to your Medical Plan.
5. Surgical repositioning of teeth - Please submit to your Medical Plan.
6. Inpatient or outpatient hospital expenses - Please submit to your Medical Plan.
7. Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa. - Please submit to your Medical Plan.
8. Surgical removal of impacted tooth - Please submit to your Medical Plan.
9. Surgical removal of residual tooth roots - Please submit to your Medical Plan.
10. Oroantral fistula closure - Please submit to your Medical Plan.
11. Tooth reimplantation - accidentally evulsed or displaced tooth - Please submit to your Medical Plan.
12. Sinus Perforation - Please submit to your Medical Plan.
13. Surgical exposure of impacted or unerupted tooth to aid eruption - Please submit to your Medical Plan.
14. Biopsy of oral tissue - Please submit to your Medical Plan.
15. Transseptal fiberotomy - Please submit to your Medical Plan.
16. Alveoloplasty - Please submit to your Medical Plan.
17. Vestibuloplasty - Please submit your Medical Plan.

18. Excision of benign/malignant lesion - Please submit your Medical Plan.
19. Incision & drainage of abscess - Please submit your Medical Plan.
20. Removal or nonodontogenic or odontogenic cyst or tumor - Please submit to your Medical Plan.
21. Partial ostectomy/sequestrectomy for removal of non-vital bone - Please submit to your Medical Plan.
22. Radical resection of mandible with bone graft - Please submit to your Medical Plan.
23. Radical excision - Please submit to your Medical Plan.
24. Removal of Torus Palatinus or Torus madibularis - Please submit to your Medical Plan.
25. Removal of foreign body - Please submit to your Medical Plan.
26. Maxillary sinusotomy for removal of tooth fragment or foreign body - Please submit to your Medical Plan.
27. Treatment of Compound fractures - Please submit to your Medical Plan.
28. Temporomandibular Joint Disorder (TMJ) - Please submit to your Medical Plan.
29. Suture of small wounds - Please submit to your Medical Plan.
30. Complicated sutures - Please submit to your Medical Plan.
31. Repair of maxillofacial soft and hard tissue defect - Please submit to your Medical Plan.
32. Frenulectomy (frenectomy or frenotomy) - Please submit to your Medical Plan.
33. Excision of hyperplastic tissue - Please submit to your Medical Plan.
34. Implant-mandible for augmentation purposes - Please submit to your Medical Plan.
35. Surgical reduction of fibrous tuberosity - Please submit to your Medical Plan.
36. Sislolithotomy - Please submit to your Medical Plan.
37. Excision of salivary gland - Please submit to your Medical Plan.
38. Sialodochoplasty - Please submit to your Medical Plan.
39. Closure of salivary fistula - Please submit to your Medical Plan.
40. Emergency tracheotomy - Please submit to your Medical Plan.
41. Cornoidectomy - Please submit to your Medical Plan.
42. Tooth transplantation - Please submit to your Medical Plan.
43. Surgical access to erupted tooth - Please submit to your Medical Plan.

COMPLEX OR MAJOR RESTORATIVE SERVICES

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

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Posterior (back) Teeth Composite (white) Resin Restorations - If the posterior (back) tooth requires a restoration due to decay or fracture.

Gold foil restorations

Inlays

Onlays

Permanent Crowns

Implant Crowns - See Prosthetic Services.

Crown Repair

Restorative cast post and core build-up, including post and pin

Canal prep & fitting of preformed dowel & post

Occlusal guard (Bruxism only)

Occlusal adjustments

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
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. Temporary, provisional or interim crown.
5. Veneers.

PROSTHETIC SERVICES (DENTURES, PARTIALS, AND BRIDGES)

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

Adjustments

Removable Prosthetic Services (Dentures and Partials)

Fixed Prosthetic Services (Bridge)

Fixed Partial Denture Retainers (Inlays, Onlays, Crowns)

Single Tooth Implant Body, Abutment and Crown - Covered 1 time per 5-year period for covered persons age 16 and over. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

> LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a Pretreatment Estimate be requested to estimate the amount of payment prior to beginning treatment.

Restorative cast post and core build-up, including pins and posts.

EXCLUSIONS - Coverage is NOT provided for:

1. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
2. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.

3. 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.
4. Services or supplies that have the primary purpose of improving the appearance of your teeth.
5. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.

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.

Repair or replacement of lost/broken/stolen appliances

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

EXCLUSIONS - Coverage is NOT provided for:

1. Monthly treatment visits that are inclusive of treatment cost.
2. Inpatient or outpatient hospital expenses.
3. Osteoplasty - Please submit to your Medical Plan.
4. LeFort procedures - Please submit to your Medical Plan.
5. Appliance removal (not by dentist who placed appliance), includes removal of archbar - Please submit to your Medical Plan.
6. Tooth transplantation - Please submit to your Medical Plan.
7. Surgical exposure of impacted or unerupted tooth for Orthodontic - Please submit to your Medical Plan.
8. Device placement.

Orthodontic Payments

Benefit payments are made when treatment begins (appliances are installed), until the lifetime maximum benefits are exhausted (see Benefit Maximums in this Plan Summary).

Before treatment begins, the treating dentist should submit a Pre-treatment Estimate. 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 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, a benefit payment will be issued.

Exclusions

Coverage is NOT provided for:

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

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

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 - Please submit to your Medical Plan.

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, medicines, or drugs for non-surgical or surgical dental care, when done alone or in conjunction with a non-covered service.

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

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

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

n) Case presentations

o) Incomplete, interim or temporary services.

p) Corrections of congenital conditions during the first 24 months of continuous coverage under this Plan Please submit to your Medical Plan.

q) Athletic mouth guards, enamel microabrasion and odontoplasty.

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

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

t) Bacteriologic tests.

u) Cytology sample collection - Please submit to your Medical Plan.

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

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

x) Veneers.

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 - Please submit to your Medical Plan.

cc) Accession of tissue - Please submit to your Medical Plan.

dd) Apicoectomy/Periradicular Services - Please submit to your Medical Plan.

ee) Root Amputation - Please submit to your Medical Plan.

ff) Hemisection, includes root removal - Please submit to your Medical Plan.

gg) Surgical procedure for isolation of tooth with rubber dam - Please submit to your Medical Plan.

hh) Complex Surgical Periodontal Care - Surgical treatment for diseases for the gingival (gums) and bone supporting the teeth - Please submit to your Medical Plan.

ii) Bone replacement graft - Please submit to your Medical Plan.

jj) Guided tissue regeneration - Please submit to your Medical Plan.

kk) Soft tissue allograft - Please submit to your Medical Plan.

ll) The controlled release of biologic materials used to aid in soft tissue and osseous tissue regeneration - Please submit to your Medical Plan.

mm)Therapeutic agent - Please submit to your Medical Plan.

nn) Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa - Please submit to your Medial Plan.

oo) Surgical removal of impacted tooth - Please submit to your Medical Plan.

pp) Surgical removal of residual tooth roots - Please submit to your Medical Plan.

qq) Oroantral fistula closure - Please submit to your Medical Plan.

rr) Tooth reimplantation - accidentally evulsed or displaced tooth - Please submit to your Medical Plan.

ss) Sinus Perforation - Please submit to your Medical Plan.

tt) Surgical exposure of impacted or unerupted tooth to aid eruption - Please submit to your Medical Plan.

uu) Biopsy of oral tissue - Please submit to your Medical Plan.

vv) Transseptal fiberotomy - Please submit to your Medical Plan.

ww)Alveoloplasty - Please submit to your Medical Plan.

xx) Vestibuloplasty - Please submit your Medical Plan.

yy) Excision of benign/malignant lesion - Please submit your Medical Plan.

zz) Incision & drainage of abscess - Please submit your Medical Plan.

aaa)Surgical repositioning of teeth - Please submit to your Medical Plan.

bbb)Removal or nonodontogenic or odontogenic cyst or tumor - Please submit to your Medical Plan.

ccc)Partial ostectomy/sequestrectomy for removal of non-vital bone - Please submit to your Medical Plan.

ddd)Radical resection of mandible with bone graft - Please submit to your Medical Plan.

eee)Radical excision - Please submit to your Medical Plan.

fff) Removal of Torus Palatinus or Torus madibularis - Please submit to your Medical Plan.

ggg)Removal of foreign body - Please submit to your Medical Plan.

hhh)Maxillary sinusotomy for removal of tooth fragment or foreign body - Please submit to your Medical Plan.

iii) Treatment of Compound fractures - Please submit to your Medical Plan.

jjj) Temporomandibular Joint Disorder (TMJ) - Please submit to your Medical Plan.

kkk)Suture of small wounds - Please submit to your Medical Plan.

lll) Complicated sutures - Please submit to your Medical Plan.

mmm)Repair of maxillofacial soft and hard tissue defect - Please submit to your Medical Plan.

nnn)Osteoplasty - Please submit to your Medical Plan.

ooo)LeFort procedures - Please submit to your Medical Plan.

ppp)Frenulectomy (frenectomy or frenotomy) - Please submit to your Medical Plan.

qqq)Excision of hyperplastic tissue - Please submit to your Medical Plan.

rrr) Appliance removal (not by dentist who placed appliance), includes removal of archbar - Please submit to your Medical Plan.

sss)Implant-mandible for augmentation purposes - Please submit to your Medical Plan.

ttt) Surgical reduction of fibrous tuberosity - Please submit to your Medical Plan.

uuu)Sislolithotomy - Please submit to your Medical Plan.

vvv) Excision of salivary gland - Please submit to your Medical Plan.

www)Sialodochoplasty - Please submit to your Medical Plan.

xxx) Closure of salivary fistula - Please submit to your Medical Plan.

yyy) Emergency tracheotomy - Please submit to your Medical Plan.

zzz)Cornoidectomy - Please submit to your Medical Plan.

aaaa)Tooth transplantation - Please submit to your Medical Plan.

bbbb)Surgical access to erupted tooth - Please submit to your Medical Plan.

cccc) Device placement.

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

LIMITATION:

Hospital and other expenses incurred in connection with dental work or oral surgery for the repair of natural teeth or other body tissues and which are required as a result of a non-occupational accidental bodily Injury within two years of the date of the Injury should be submitted to the Medical Plan. Both the injury and dental work or oral surgery must occur while the individual is eligible for benefits.

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

Post Payment Review

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

ELIGIBILITY - Please refer to the Pipe Trades Services MN **Welfare Fund SPD for Eligibility descriptions and definitions.**

Please refer to the PIPE TRADES SERVICES MN WELFARE FUND SPD for COBRA eligibility

PLAN PAYMENTS

Participating Dentist Network

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

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

Listings of participating providers are available to Subscribers as a separate document and are furnished by the Group without charge. Names of Participating Dentists can be obtained, upon request, by calling Delta, from directory listings furnished to the Group 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 participating Delta Dental PPO/Delta Dental Premier dentist with the plan. There may also be a difference in the payment amount if your dentist is not a participating dentist with Delta. This payment difference could result in some financial liability to you. Claim payments are based on the treating dentist's submitted charge, not to exceed the reasonable and customary schedule established by the Plan.

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

Claim Payments

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

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

Delta Dental Premier Dentists:

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

Delta Dental PPO Dentists:

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

Nonparticipating Dentists:

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

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

Coordination of Benefits (COB)

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

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

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

Assignment of Benefits

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

Claim and Appeal Procedures

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

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

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

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

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

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

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.

GENERAL INFORMATION

Health Plan Issuer Involvement

The benefits under the Plan are not guaranteed by Delta under the Contract. As Claims Administrator, Delta 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.

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 Welfare Plan is providing the Dental program.**

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

Using Your Dental Program

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

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

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

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

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

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

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

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

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

Cancellation and Renewal

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

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

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 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.

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
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