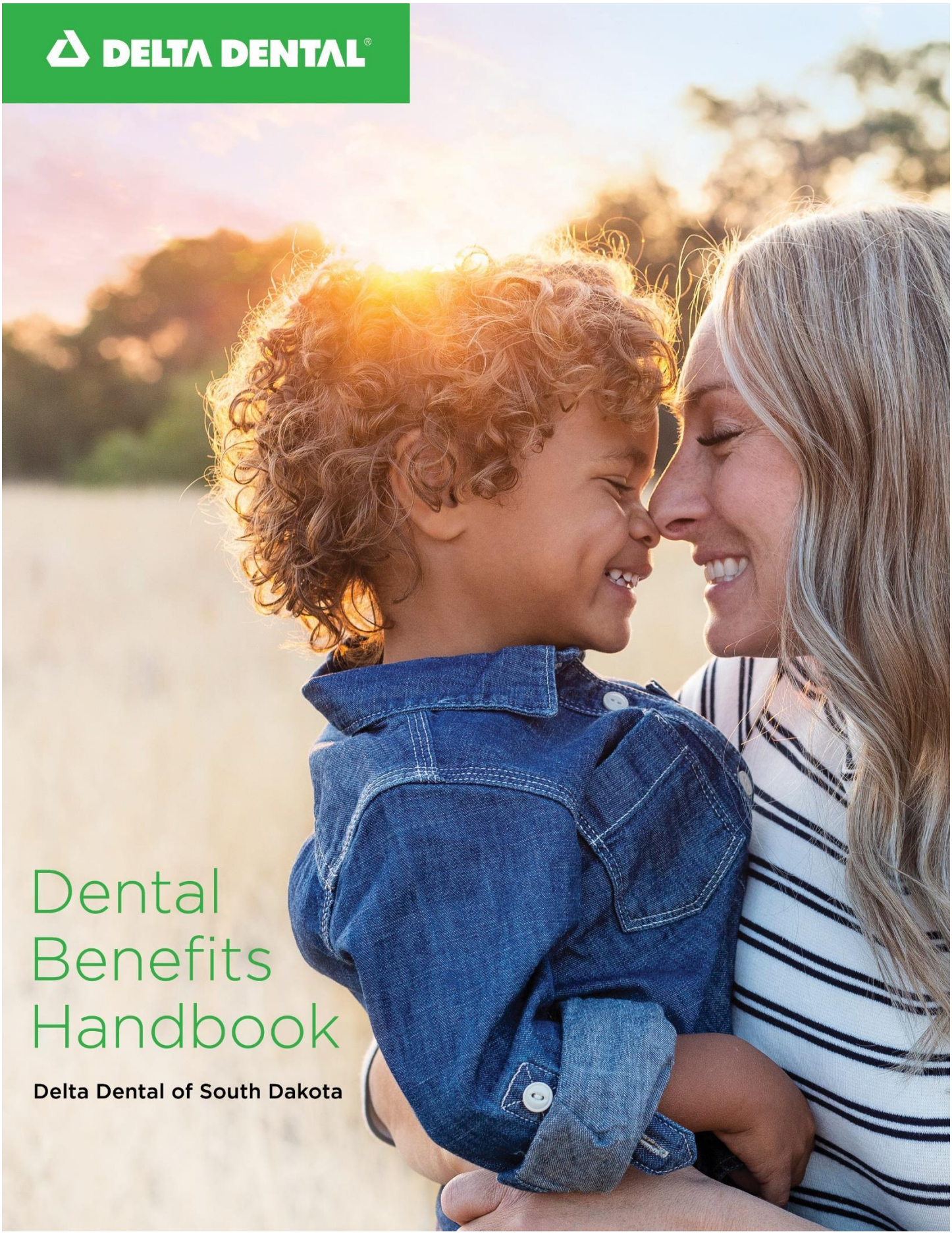
DELTA DENTAL®



Dental Benefits Handbook

Delta Dental of South Dakota

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Introduction

Delta Dental of South Dakota has been selected by your employer to provide your group dental coverage. All of us at Delta Dental are pleased to bring these important benefits to you and any dependents you have enrolled for coverage.

It is important for you to read this dental benefit handbook and to familiarize yourself with your summary of benefits. The summary of benefits lists the specific benefits of your group dental coverage. If you do not have a copy of your summary of benefits, contact your human resources office. Together, the dental benefit handbook and the summary of benefits are your certificate of insurance.

This handbook is not the insurance policy. It is merely evidence of insurance provided under the contract between Delta Dental and your employer. All benefits are paid according to the terms, conditions, and provisions of your group's contract. This handbook describes the essential features of such insurance. This handbook replaces and supersedes all booklets, endorsements, and riders that we may have previously issued to you prior to the effective date of this handbook. The contract issued to your employer is the complete document of insurance and governs all claims processing. It will serve as Delta Dental's primary resource when answering questions regarding your dental claims. You may examine your group's contract any time by contacting your employer or Delta Dental during normal business hours.

Language Assistance

If you cannot read this document, we can have someone help you read it. For help, please call Delta Dental at 1-877-841-1478 and we will connect you with a translator.

Definitions

Abfraction is a loss of tooth structure that is not caused by tooth decay, located along the gum line.

Alternate benefit is a benefit based on an alternative procedure that is generally less expensive than the one provided or proposed.

Amalgam is a silver material used to fill cavities that is placed on the tooth surface (that is used for chewing) because it is a particularly durable material.

Annual maximum benefit is the maximum benefit each enrollee is eligible to receive for covered services in a coverage year. The annual maximum benefit is reached from claims paid in a coverage year. This amount is shown on the summary of benefits. Refer to the summary of benefits to see if you have a separate lifetime benefit for orthodontics (braces), TMJ, or implant services.

Apicoectomy is a surgical removal of the apex or tip of a root to remove diseased tissue.

Approved amount is the total amount that the dentist is permitted to collect as payment in full for the specified service. It includes the dental benefit plan's payment as well as the patient's deductible and/or co-insurance.

Attrition is a type of tooth wear caused by tooth-to-tooth contact, resulting in loss of tooth tissue.

Benefits are services covered under a dental plan.

Caries is a term that is used for tooth decay.

COBRA or Consolidated Omnibus Budget Reconciliation Act is a law that requires certain employers to offer continued health insurance coverage to eligible employees and/or their dependents who have had their health insurance coverage terminated.

Co-insurance is the percentage of dental expenses you pay after the deductible is met, until you reach your annual maximum benefit.

Co-payment is a fixed dollar amount paid each time certain covered services are received.

Completion date is the date a procedure is completed. It is the insertion date for dentures and the cementation date for inlays, onlays, crowns, and bridges.

Composite is a white resin material used to fill cavities which has less durability; thus, it is placed on non-stress bearing surfaces of front teeth because the color more closely resembles the natural tooth than does the color of amalgam.

Coverage percentage means the percentage of the maximum plan allowance paid by Delta Dental for a specific benefit, as specified in the summary of benefits.

Coverage year is the 12-month period over which a group's deductibles, maximums and other provisions apply. This may or may not be the same as a calendar year. Also known as the benefit year. Your coverage year is shown on the summary of benefits.

Crown is the artificial covering of a tooth with metal, porcelain or porcelain fused to metal and covers teeth that are weakened by decay or severely damaged or chipped.

Debridement is the removal of subgingival and/or supragingival plaque and calculus to complete an oral evaluation.

Deductible is the dollar amount you pay for covered services before benefits are available under this handbook. This amount is shown on the summary of benefits. The family deductible is reached from deductible amounts paid on behalf of any combination of members.

Dependents are a subscriber's spouse, and children (under age 19, unless otherwise noted on the summary of benefits).

Dentures (complete/partial) replace missing permanent teeth with a removable set of artificial teeth.

Endodontist is a dentist who specializes in diseases of the tooth pulp, performing such services as root canals.

Exclusion is a dental service or procedure not covered by a dental program.

Explanation of benefits (EOB) is a statement sheet that explains how your claim was processed, payment by Delta Dental, your payment responsibility, and other pertinent information.

Fluoride is a chemical compound that prevents cavities and makes the tooth surface stronger so that teeth can resist decay.

General anesthesia is a drug induced state of unconsciousness determined by the provider to complete treatment.

General dentist is a dentist who provides a full range of dental services for the entire family.

Grievance is any dissatisfaction with the services provided by your dentist expressed in writing by or on behalf of you or your covered dependent.

HIPAA (Health Insurance Portability and Accountability Act of 1996) is United States legislation that provides data privacy and security provisions for safeguarding medical information.

ID number is the unique number assigned by the administrator of your dental plan or the Social Security number of the primary subscriber.

Implant is a material inserted or grafted into tissue. Dental implant is a device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing dental replacement.

Late enrollee is a subscriber or dependent that does not enroll in the plan when initially eligible.

Lifetime maximum means that, in a member's lifetime, total benefits are limited by dollar amount for the benefit category of orthodontics (braces). This amount is shown on the summary of benefits.

Maximum plan allowance is the amount that Delta Dental will pay for a service, supply, or dental procedure. The maximum plan allowance is established by Delta Dental of South Dakota and is developed from various sources, such as agreements with dentists, input from dental consultants, the simplicity or complexity of the procedure, and the charges for procedures by dentists in South Dakota. For services billed by dentists outside of South Dakota, the maximum plan allowance is based on information from the Delta Dental within that state.

Non-participating dentist is a state-licensed dentist who does not have a written participation agreement with Delta Dental.

Open enrollment is the time in which an employee can enroll or make changes to their coverage (e.g., change from single coverage to family, add or drop dependents, etc.).

Orthodontics is the correction of misaligned teeth and jaw or the straightening of teeth, including the use of braces.

Orthodontist is a type of dentist who specializes in the correction of misaligned teeth and jaws, usually by applying braces.

Oral surgeon is a type of dentist who specializes in removing teeth, including impacted wisdom teeth, repairing fractures of the jaw and other damage to the bone structure around the mouth.

Participating dentist is a licensed dentist who has signed a Delta Dental service agreement. Delta Dental's payment and the patient's payment, if any, are to be accepted by the contracting dentist as payment in full. Delta Dental's payment is sent directly to the contracting dentist. To find a participating dentist go to www.deltadentalsd.com. Click on "Find a Dentist" and enter your city or zip code.

Pediatric dentist is a dentist who generally limits his/her practice to children and teenagers. Also known as Pedodontist.

Periodontist is a dentist who specializes in the treatment of diseases of the gums.

Periodontal scaling/root planing is the removal of hard deposits, with metal scalers and curettes, on the root surfaces. The intent is to remove the diseased elements of the root surface, thereby permitting healing and potential reduction in depth of the periodontal pocket.

Primary insurance is the insurance carrier or third-party payee that pays for services rendered to a covered person before any other carrier.

Prophylaxis is a professional cleaning to remove plaque, tartar (calculus), and stain from teeth to help prevent dental disease.

Pulpotomy is a partial removal of the pulp.

Root canal therapy is the treatment of a tooth having a damaged pulp; usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with inert sealing material.

Sealant is a thin plastic material used to cover the biting surface of a tooth to prevent tooth decay.

Secondary insurance is the insurance carrier or third-party payee that would process its payment for a claim after a primary carrier made payment and make any additional payments as necessary.

Space maintainer is a mechanical or prosthetic device used to prevent the drifting of teeth in an area where there has been premature loss of a tooth or teeth.

Subscriber means an eligible employee or member of the group who (a) has completed and signed the documents necessary for coverage under the contract, (b) has been accepted by Delta Dental as a subscriber, and (c) for whom the appropriate premium has been paid.

Summary of benefits is a listing of the specific benefits and benefit limitations for dental services provided under the terms of your group's contract. If you do not have a copy of your summary of benefits, contact your human resources office.

Treatment plan is a written document prepared by a dentist showing the dentist's recommended treatment.

Waiting period is a period defined by the dental contract before benefits are covered.

Wisdom tooth is the adult molar tooth that is furthest back in the mouth. Also called a third molar. There are four third molars, two in the lower jaw and two in the upper jaw, one on each side.

Choice of Provider Network

With a Delta Dental PPO Plus Premier℠ dental plan you have access to two Delta Dental networks which are described below. You simply go to the dentist of your choice.

Delta Dental Premier Providers and PPO Providers have agreed to accept Delta Dental's payment as the full payment for the benefit provided and will not charge you any fees other than your coinsurance, deductible, and any dental procedure not covered under this policy.

The Delta Dental Premier network offers you more flexibility in choosing a provider. If you have a Delta Dental PPO Plus Premier plan in most cases, you'll get the best out-of-pocket savings by choosing a Delta Dental PPO Provider. All Delta Dental providers submit claims to Delta Dental and Delta Dental will issue payment directly to the Delta Dental provider.

If you choose a non-participating dentist, they have not agreed to accept Delta Dental's payment or our discounted fees. You will be responsible for paying any fees over and above Delta Dental's payment and for making sure claim forms are completed and sent to us.

Finding a participating dentist is easy. Visit www.deltadentalsd.com or download our Mobile app. Click on Find a Dentist and select your plan. Refer to your ID card to determine if you have a Delta Dental PPO Plus Premier℠ plan or a Delta Dental Premier plan.

Participating Dentists

Advantages of going to a participating dentist:

- Participating dentists agree to file claims for you.
- Claims are paid directly to participating dentists. You are responsible to pay your dentist for any deductible, co-insurance, or non-approved charge.
- Participating dentists agree to file a predetermination of benefits when you have a treatment plan exceeding $750 or if the proposed treatment plan involves crowns, bridges, dentures, or implants.

Non-Participating Dentists

When you go to a non-participating dentist, you will be responsible for the following:

- You are responsible for any difference between their charge and what Delta Dental pays.
- Non-participating dentist are not responsible for filing your claims. Claims must be received by Delta Dental within one year of the date the dental services are completed.
- Claims are paid to you. You are responsible for paying your dentist for claims as well as any deductible, coinsurance, or non-approved charge.
- Non-participating dentists do not agree to file a predetermination of benefits for you.
- Non-participating dentists may charge for "infection control", which includes the costs for services and supplies associated with sterilization procedures. You are responsible for any extra charges billed by a non-participating dentist for "infection control." (All dentists are legally required to follow certain guidelines to protect their patients and staff from exposure to infection. However, Delta Dental dentists incorporate these costs into their normal fees and do not charge an additional fee for "infection control.")

Filing Claims

Once you receive dental services, Delta Dental needs to receive a claim to determine the amount of your benefits. The claim lets us know the services you received, when you received them, and from which dentist.

Claim forms

A participating dentist will submit claims for you. If you receive services from a non-participating dentist, you may need to file your own claim. To request a claim form contact us at 1-877-841-1478 or visit our website, www.deltadentalsd.com and log into your account.

Mail the claim form to:
Claims Department
Delta Dental of South Dakota
PO Box 1157
Pierre, SD 57501

When to file your claim

After your procedure is finished, you should file a claim if your dentist has not filed one for you. Delta Dental makes payment only upon final completion of a service. For example, we will send payment when: a permanent crown, bridge, partial or denture is placed, not the temporary procedure placed prior to you receiving the final treatment procedure. Delta Dental will not pay claims submitted more than 12 months after the date the service was provided.

Reasons your claim may be denied

Even though a procedure may appear in the Benefits section, you should note that before you are eligible to receive benefits, we consider the following:

- Procedures must be dentally necessary or appropriate and meet national accepted standards of dentistry.
- Procedures must be a benefit. See Exclusions section.
- Procedures may have limitations associated with them. For example, teeth cleaning is covered twice per coverage year. More frequent teeth cleaning is not always a benefit even if your dentist verifies that it is dentally necessary and dentally appropriate. See the Benefits section for a description of covered procedures and limitations associated with certain procedures.
- The annual maximum benefit may have been reached. See the summary of benefits.
- The waiting period of the contract may not have been satisfied.
- The patient is not eligible at the time of service.
- Any difference between the charge and what Delta Dental allows. Please note: This only applies if you receive services from a non-participating dentist.

Benefits

See the Summary of Benefits for age and frequency limitations.

Preventive Care

Cleaning (Prophylaxis)
A standard tooth cleaning for the prevention of dental disease involving the removal of plaque, tartar (calculus), and staining.

Exam
An inspection of the teeth and surrounding soft tissues of the oral cavity.

Fluoride Applications
The delivery of fluoride to the teeth to protect them from dental cavities. *Limitation: Fluoride applications are a benefit only when applied by dental professionals.*

X-Rays
Pictures of the teeth, bones, and soft tissues to help find problems with the teeth, mouth, and jaw.

Bitewing X-Rays
Image of the upper and lower back teeth generally taken to check for decay between the teeth, show bone loss and/or dental infection.

Full-Mouth/Panoramic X-Rays
A series of pictures or a single picture that show all teeth in one image as well as the surrounding bone and other structures taken by a dentist on the same service date.

Occlusal and Extraoral X-Rays
Pictures showing the roof or floor of the mouth*. Limitation: These x-rays are a benefit once per coverage year.*

Periapical X-Rays
Pictures showing the entire tooth from the crown of the tooth to the root and the supporting bone around the tooth. *Limitation: These x-rays are a benefit on an "as needed basis" determined by your dentist, not to exceed benefits/limitations outlined as full-mouth x-rays.*

Diagnostic Casts
A cast model of a person's teeth that is used to guide in the treatment of corrective or restorative dentistry. *Limitation: Diagnostic casts are only a benefit in conjunction with orthodontic treatment. The fee for the cast is included as part of the total orthodontic treatment cost.*

Space Maintainers for Missing Primary Back Teeth
A procedure that helps hold the space for a permanent tooth due to the early loss of a baby tooth.

Sealant Applications
Filling decay-prone areas of the chewing surface of molars. *Limitation: Sealant replacement is limited to once every 36 months.*

Fillings and Extractions

Fillings
Restoring the tooth with a silver (amalgam) or tooth colored (composite) filling. *Limitation: If a tooth-colored filling is used to restore back (posterior) teeth, benefits are limited to the amount paid for a silver filling. You are responsible for paying the difference. Limitation: Routine (Minor) fillings are covered once per surface in a 24-month period.*

Limitation: Restorations for the main purpose of cosmetics or restoring a tooth due to wear, also known as attrition, abrasion, erosion, and abfractions are not a benefit.

Stainless-steel crowns
Limitation: Stainless-steel crowns are limited to once per lifetime per tooth.

Routine Oral Surgery
Removal of teeth, and other surgical services to the teeth or immediate surrounding hard and soft tissues that are being performed due to disease, pathology, or dysfunction. *Limitation*: *A predetermination of benefits is required for wisdom teeth (third molars) extractions.*

Limitation: Other than the removal of teeth, most oral surgery procedures such as removal of tumor and repair or reconstruction of jaws or the joints in your jaw are considered a medical benefit and payable by your medical carrier.

Emergency Treatment
A short-term or temporary measure to relieve pain or infection.

Local and or General Anesthesia/Sedation
A type of medication that results in the loss of ability to feel pain. General anesthesia/sedation that produces partial or complete unconsciousness. *Limitation: Local anesthesia is considered a part of the dental treatment and as such is not a separate benefit.*

Limitation: General anesthesia and intravenous sedation are benefits only when provided in conjunction with six or more routine extractions, surgical extractions, and other covered surgical procedures and when billed by the treating dentist. It is not a benefit for restorative procedures.

Athletic Mouth Guard
Covered once every 24 months for children up to age 18.

Root Canals

Root Canal
Treating an infected or injured pulp to retain tooth function. This procedure generally involves removal of the pulp and replacement with an inert filling material. *Limitation: If retreatment is required, it is a benefit following 24 months from the completion of the original root canal and limited to one retreatment per tooth.*

Apicoectomy/Periarticular Surgery
Surgery to repair a damaged root as part of root canal therapy or to correct a previous root canal.

Pulpotomy
Removal of the innermost most center part of the tooth or the pulp of the root.

Retrograde Fillings
Sealing the root canal by preparing and filling it from the root end of the tooth. *Limitation: This procedure is a benefit once per root.*

Pulp caps
Pulp cap procedures are not a benefit.

Gum Disease Treatments

Procedures in this category require a predetermination of benefits.

Full Mouth Debridement (Difficult Cleaning)
A deep cleaning of teeth to remove several years of plaque from the teeth. It is the gross removal of bacterial plaque and calculus (tartar) that interfere with the ability of the dentist to perform an exam. *Limitation:* A full mouth debridement is a once in a lifetime benefit provided you have no history of a difficult cleaning while covered by Delta Dental of South Dakota.

Non–Surgical (Conservative) Periodontal Procedures (Root Planing and Scaling)
A non-surgical removal of bacterial plaque and tartar (calculus) from a tooth root to prevent or treat disease of the gum tissues and bone which support it. *Limitation: Non-surgical (Conservative) periodontal procedures are a benefit once every 24 months for each quadrant of the mouth. Only two quadrants of root planing and scaling is allowable per visit. A quadrant is one of the four equal sections of the mouth into which the jaws can be divided*.

Surgical (Complex) Periodontal Procedures
Surgical procedures designed to repair and regenerate gum and bone tissues that support the teeth. *Limitation: Surgical (Complex) periodontal procedures are a benefit once every 36 months for each quadrant of the mouth for natural teeth only.*

Limitation: If a non-surgical periodontal procedure is followed by surgical periodontal procedures, a minimum of four weeks must lapse for healing purposes before the surgical procedure will be a benefit.

Bone Grafts
A surgical procedure that replaces missing bone. *Limitation: Bone grafts are only a covered benefit for natural teeth. They are not a benefit for extraction sites or in conjunction with implants.*

Periodontal Maintenance Therapy/Cleanings
Includes pocket depth measurement, cleaning of natural teeth, removal of stain, root planing and scaling, and other surgical periodontal procedures. *Limitation: This procedure must follow conservative or complex periodontal therapy and is allowable twice per coverage year. If this procedure is performed, it replaces the dental cleaning benefit (prophylaxis) described under Preventive Care earlier in this section. If there is no active periodontal therapy, this procedure will be benefited as a routine dental cleaning.*

Crowns

Procedures in this category are covered once every five years from the date the major restoration is cemented in place. This includes teeth crowned and extracted within the five-year period and replaced with a bridge, denture, or implant crown. Procedures in this category are not a benefit under age 12.

Crowns - Single Restoration Only
A dental crown is a tooth-shaped “cap” that is placed over a tooth to help restore its shape, size, and strength. Crowns can be made of various materials. Crowns are a benefit only if the tooth cannot be restored with a routine filling.

Limitation: Crowns that are not meant to restore form and function of a tooth, including crowns placed for the primary purpose of periodontal splinting, cosmetics, altering vertical dimension/occlusion, or restoring a tooth due to allergies, attrition, abrasion, erosion and abfractions are not a covered benefit. Crowns placed on anterior teeth for endodontic purposes only are not a covered benefit. Crowns placed for fracture lines (craze lines) without actual tooth structure missing are not a benefit. Replacement of a crown due to a porcelain fracture is not a covered benefit

Limitation: Crowns are a benefit following root canal treatment only when a significant amount of tooth structure is missing due to decay and/or fracture and cannot be restored with a routine filling. If sufficient tooth structure remains, benefits are not allowed.

Limitation: Coverage for a porcelain crown is limited to the six front teeth on both the upper and lower jaw. When a porcelain crown is placed on teeth other than the six front, an alternate allowance for a porcelain fused to metal crown will be benefited on the bicuspids and 1st molars, and an all base metal crown will be benefited on the 2nd and 3rd molars.

Build-ups
A restorative procedure where a missing portion of a tooth is required to be restored with a filling to support a crown. *Limitation: Build-ups are a covered benefit only when necessary to retain/support a crown. If a tooth can be restored with a routine filling, the build-up and crown will not be a covered benefit.*

Inlay Restorations
A restoration (typically gold, porcelain or composite) processed outside the mouth and then fixed into a cavity inside the tooth. Inlays are done on back teeth.

Limitation: Inlays are limited to the amount paid for a silver (amalgam) filling. If a tooth-colored material is used to restore back (posterior) teeth, benefits are limited to the amount paid for a silver filling. You are responsible for paying the difference. These benefits are covered once per surface in a 24-month period. Restorations for the primary purpose of cosmetics or restoring a tooth due to attrition, abrasion, erosion, and abfractions are not a benefit.

Onlay Restorations
An onlay replaces or covers a cusp of the tooth. The same criteria for benefiting a crown applies to an onlay.

Post and Core
A dental procedure that is used to prepare a tooth for a cast restoration after a root canal when there is insufficient retention to place the cast restoration. *Limitation: This procedure is a covered benefit once in a five-year period from the date the previous post and core or core build-up was cemented in place.*

Recementation of Major Restorations
Limitation: Benefits are limited to once per lifetime per tooth.

Prosthetics

Prosthetics are fixed bridges, dentures, and implants used to replace missing permanent teeth. *Limitation: Procedures in this category are not a benefit under the age of 16.*

Limitation: Bridges, dentures, denture rebase, and implants are a benefit once every five years from the date of initial placement and then only if the existing prosthetic is unserviceable whether Delta Dental paid for the original dental procedure under this plan. Bridges, dentures, and implants are provided when chewing function is impaired due to missing teeth.

Bridges and Bridge Repair
Replacing missing permanent teeth with a dental prosthesis that is cemented in place and can only be removed by a dentist. *Limitation: Bridges which are supported by dental implants are limited to the amount paid for a conventional bridge supported by natural teeth.*

Dentures (Complete and Partial)
Replacing missing permanent teeth with a dental prosthesis that is removable.

Limitation: Temporary dentures (Complete or Partial) are not a covered benefit. Charges for duplicate dentures are not covered.

Limitation: Dentures which are supported by surgically placed dental implants will be limited to the amount paid for a conventional complete denture.

Denture Adjustments
Limitation: Denture adjustments are limited to two per denture per coverage year after six months has elapsed since initial placement.

Denture Reline
Limitation: Denture relines will be limited to once every three years after six months initial placement.

Denture Rebase
Limitation: Denture rebase will be limited to once every five years.

Tissue Conditioning
Limitation: Tissue conditioning is limited to two per denture every 36 months.

Implants
Coverage is provided when chewing function is impaired due to missing teeth and could include surgical placement or removal of implants or attachments to implant.

Braces and Teeth Alignment

Treatment necessary for the proper alignment of teeth.

When an orthodontic treatment plan is submitted and approved, Delta Dental of South Dakota will make an initial payment of up to $1,000. If your lifetime orthodontic maximum (see the summary of benefits) is greater than $1,000, a second payment will be made 12 months later if coverage still exists.

If orthodontic treatment is stopped for any reason before it is completed, Delta Dental of South Dakota will only pay for services and supplies received. No benefits are available for charges made after treatment stops.

Delta Dental's payment for treatment in progress extends only to the months of treatment received while covered under the plan. Delta Dental will determine the months eligible for coverage.

Limitation: A predetermination of benefits is required on alternative (plastic aligners) orthodontic treatment plans (e.g., Smile Direct Club, Candid, Smilelove). Orthodontic treatment that is not under the direct care of a dentist or orthodontist will not be covered.

Limitation: Surgical exposure of impacted or unerupted teeth for orthodontic reasons are not covered unless you have orthodontic coverage.

Limitation: Repair or replacement of any orthodontic appliance is not covered, even if orthodontics is a covered benefit.

Diagnostic Cast
Limitation: Diagnostic cast is a benefit only in conjunction with orthodontic treatment. The fee for the cast is included as a part of the total orthodontic treatment cost.

Health through Oral Wellness®

(check the summary of benefits to see if you have this benefit)
Health through Oral Wellness® is a unique, patient-centered program that adds benefits to a Delta Dental plan based on individual oral health needs. A Delta Dental network dentist trained in Health through Oral Wellness® will conduct a clinical risk assessment during a regular preventive visit. The assessment measures the risk and severity of periodontal disease, and the risk of tooth decay.

If the assessment determines a member is at risk for tooth decay, additional benefits include fluoride treatments, sealants, and oral hygiene instruction. If a member is at risk for periodontal (gum) disease, has periodontal disease or has had periodontal surgery, the member will be eligible for two additional cleanings* and four fluoride treatments.

If a member has any of the following health conditions, they are eligible for additional benefits.

- Diabetes (2 additional cleanings*)
- High-risk cardiac care (2 additional cleanings*)
- Kidney failure or dialysis (2 additional cleanings*)
- Cancer-related treatment - chemotherapy or radiation (2 additional cleanings* and 2 applications of fluoride varnish)
- Suppressed immune system (2 additional cleanings* and 2 applications of fluoride varnish)
- Rheumatoid arthritis (2 additional cleanings*)
- Stroke (2 additional cleanings*)
- Pregnancy (1 additional cleaning* during the time of pregnancy)

** Cleanings can either be a general cleaning (prophylaxis) or a periodontal maintenance cleaning. Periodontal maintenance cleanings are typically covered under the "Gum Disease Treatments" category, not the "Preventive Care" category.*

Exclusions

Call us at 1-877-841-1478 if you are unsure if a certain service is covered.

Allergies
You are not covered for restorations or procedures due to allergies or allergic reaction to dental treatment materials such as allergies to metals or mercury.

Anesthesia or analgesia
You are not covered for local anesthesia or nitrous oxide (relative analgesia) when billed separately from the related procedure. This exclusion does not apply to general anesthesia or intravenous sedation administered in connection with covered oral surgery as described in the Benefits section.

Appliances, restorations, or procedures for:

- increasing vertical dimension;
- restoring occlusion;
- correcting harmful habits;
- replacing tooth structure lost by attrition, abrasion, erosion and abfractions;
- correcting congenital or developmental malformations;
- temporary dental procedures;
- splints, unless necessary because of accidental injury;

Broken or missed appointments
You are not covered for any charges for failure to keep a scheduled visit with your dental provider.

Cleaning of prosthetic appliance
Your plan does not cover the cost of cleaning removable partials or dentures.

Completion of form
Your plan does not cover any charges to complete forms.

Complete occlusal adjustment
You are not covered for services or supplies used for revision or alteration of the functional relationships between upper and lower teeth unless otherwise noted on the summary of benefits.

Complications of a non-covered procedure
You are not covered for complications of a non-covered procedure.

Congenital deformities
You are not covered for services or supplies to correct congenital deformities.

Consultation charges
The charge for a practitioner's opinion or advice given in-person, by phone or other electronic means is not a covered service.

Controlled release device (antimicrobial agents)
The use of localized delivery of antimicrobial agents as part of the overall management of periodontal disease is not a covered benefit.

Correction of occlusion
You are not covered for the correction of occlusion when performed with prosthetics and restorations involving occlusal surfaces.

Cosmetic in nature
You are not covered for services or supplies which have the primary purpose of improving the appearance of your teeth, rather than restoring or improving dental form or function or the treatment of dental disease.

Dental procedures:
- Provided by other than a dentist or licensed hygienist employed by a dentist.
- To treat injuries or diseases caused by riots or any form of civil disobedience.
- To treat injuries sustained while committing a criminal act.
- To treat injuries intentionally inflicted.
- In the professional judgment of the attending dentist, a satisfactory result cannot be obtained.

Desensitization materials
You are not covered for desensitization materials or their application.

Drugs
You are not covered for prescription, non-prescription drugs, medicines, or therapeutic drug injections.

Duplication of dental records
Your plan does not cover any charges for the duplication of dental records.

Effective date
You are not covered for services or supplies received before the effective date of coverage.

Experimental or investigative
You are not covered for services or supplies that are considered experimental, investigative or have a poor prognosis. Peer reviewed outcomes data from clinical trial, Food and Drug Administration regulatory status, and established governmental and professional guidelines will be used in this determination.

Incomplete services
You are not covered for dental services that have not been completed.

Infection control
You are not covered for separate charges for "*infection control*," which includes the costs for services and supplies associated with sterilization procedures. Participating dentists incorporate these costs into their normal fees and will not charge an additional fee for "*infection control*."

Lost or stolen appliances
You are not covered for services or supplies required to replace a lost or stolen dental appliance or charges for duplicate dentures.

Medical services or supplies
You are not covered for services or supplies which are medical in nature or covered under a medical plan. These may include, but not limited to: dental services performed in a hospital, surgical treatment centers, treatment of fractures and dislocations, treatment of cysts and malignancies, and accidental injuries or treatment rendered other than by a licensed dentist.

Night guard/occlusal guards
Your plan does not cover appliances for bruxism, grinding or clenching of teeth unless your plan has coverage for temporomandibular joint (TMJ) dysfunction. Refer to the summary of benefits sheet.

Non-standard dental treatment and procedures
There is no coverage for services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.

Payment responsibility
You are not covered for services or supplies when someone else has the legal obligation to pay for your care.

Periodontal splinting
You are not covered for services or supplies used for the primary purpose of reducing tooth mobility, including but not limited to crown/bridge restorations.

Prevention control programs
Preventive control programs including but not limited to oral hygiene instructions, caries susceptibility tests, dietary control, tobacco counseling, and home care medicaments are not a covered benefit.

Services provided in other than an office setting
You are not covered for services provided in other than a dental office setting. This includes, but is not limited to, any hospital or surgical/treatment facility.

Specialized services
You are not covered for specialized, personalized, elective materials and techniques or technology which are not reasonably necessary for the diagnosis or treatment of dental disease or dysfunction. Specialized services represent enhancements to other services and are considered optional. Includes, but not limited to, copings and precision attachments.

Taxes
Provider tax, state sales tax, or medical tax is not a covered benefit.

Temporary crowns, bridges, dentures, partials, or implants
Services or supplies for temporary crowns, bridges, dentures, partials, or implants are not a covered benefit.

Temporary or interim procedures
You are not covered for temporary or interim procedures.

Temporomandibular joint (TMJ) dysfunction
You are not covered for expenses incurred for diagnostic x-rays, appliances, restorations, or surgery in connection with temporomandibular joint dysfunction or myofunctional therapy, unless temporomandibular joint (TMJ) dysfunction services are covered on the summary of benefits.

Termination
Whether or not we have approved a treatment plan, you are not covered for treatment received after you or your group's coverage termination date.

Treatment by other than a licensed dentist
You are not covered for services or treatment performed by anyone other than a licensed dentist or a licensed hygienist employed by the dentist.

Waiting Period
You are not covered for any service started during the waiting period of the contract.

Workers' compensation
You are not covered for dental procedures, supplies, treatments, or any other services to treat injuries or conditions compensable under workers' compensation or employer's liability laws.

Predetermination of Benefits

A predetermination of benefits tells you and your dentist what is covered and how much will be paid on your treatment plan. It also determines that services are dentally necessary and appropriate.

When to submit a treatment plan

After an examination, your dentist may recommend a treatment plan. If the plan involves crown(s), bridgework, dentures, or implants costing over $750 ask your dentist to send the treatment plan with x-rays to Delta Dental. If your dentist is a non-participating dentist, you will need to send the treatment plan, x-rays and supporting information to the address below. Delta Dental will determine benefit coverage, what portion of the cost we will pay and what portion you will be responsible to pay. Your dentist will receive a predetermination of benefits voucher with this information on it. The predetermination of benefits is valid for 120 days from the date issued. Before you schedule dental appointments, you and your dentist should discuss the predetermination voucher, the amount to be paid by Delta Dental, and your financial obligation for the proposed treatment.

Predetermination of Benefits
Delta Dental of South Dakota
PO Box 1157
Pierre, SD 57501

The treatment plan review

Once we receive the treatment plan and proper documentation, we will let your dentist know if the treatment plan is approved. We will take one of the following actions:

- Accept it as submitted and approve or pay according to the group contract.
- Provide an alternate benefit allowance in accordance with the dental benefits of your group.
- Deny the treatment plan due to one of the following:
    - the procedure is not a benefit under your policy;
    - Delta Dental did not receive all the necessary documentation to determine the benefit(s);
    - you did not receive an evaluation after we asked you to; or
    - the procedure is not dentally necessary and appropriate.

Reconsideration

If Delta Dental denies any of the proposed treatment, you and/or your dentist can request reconsideration. The request should be in writing along with any additional documentation that may be available. Do not have the dental office submit the claim again. Enclose a copy of the predetermination of benefits or a copy of the explanation of benefits with the written request describing the problem. If necessary, Delta Dental may ask you to get an evaluation from one of our Regional Dental Consultants. Although Delta Dental may approve a treatment plan, we are not liable for the actual treatment you receive from your dentist.

Coordination of Benefits

Filing when you have other coverage

Coordination of benefits is designed to provide maximum coverage, but not to exceed 100% of the total fee for a given treatment plan. Dual coverage does not affect benefit frequency limitations (i.e., If you are covered under two policies and each policy allows for two exams and two cleanings per year you will only be eligible for two exams and two cleanings, not four exams and four cleanings).

Most plans do not allow an internal coordination of benefits. This is when an employee and spouse work for the same employer and are covered under separate policies under that employer's Delta Dental plan. This would allow for claims to be submitted on dependents under each employee. Check with your employer to see if they allow internal coordination of benefits.

If a subscriber or eligible dependent is covered for dental benefits or services by another dental contract, arrangement, or insurance policy, Delta Dental's liability for payment will be determined on the following basis:

1. The benefits of the plan which covers the person as an employee, member or subscriber are determined before those of the plan which covers the person as a dependent;

2. If two or more plans cover the same child as a dependent of different persons:

    a. The benefits of the plan of the parent whose birthday* falls earlier in a year are determined before those of the plan of the parent whose birthday* falls later in that year;
    b. If both parents have the same birthday*, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period;
    c. If the other plan does not have the rule described in section 2.a but has a rule based upon the gender of the parent and, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;

3. If two or more plans cover a person as a dependent child of divorced or separated parents and there is no court order specifying primary insurance, benefits for the child are determined in the following order:
    a. The plan of the parent with custody of the child
    b. The plan of the spouse of the parent with custody of the child
    c. The plan of the parent not having custody of the child
    d. There are no benefits available under the plan of the spouse of the parent without custody of the child

If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, the benefits of that plan are determined first.

*The term "birthday," as used in this section, means the month and day, rather than the year, in which the person was born.

Right to receive and release needed information

Delta Dental has the right to decide the facts it needs to apply these rules. Delta Dental may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply coordination of benefits rules. Medical and dental records remain confidential as provided by applicable state and federal law. Each person claiming benefits under this plan must give Delta Dental any facts it needs to process the claim.

Right of recovery

If the amount of the payments made by Delta Dental is more than it should have paid under coordination of benefits, it may recover the excess, at its option, from one or more of: (1) the persons it has paid or for whom it has paid; (2) insurance companies; or (3) other organizations. The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

Eligibility

Covered employee

You are eligible for coverage under your group's contract - while you are a regular employee of the group, you average the number of hours as determined by the group's contract, and you have completed any waiting period indicated on the summary of benefits. You may also be covered by your group's contract if you no longer meet these conditions but have elected to continue coverage as described in the Continued Coverage (COBRA) section of this handbook.

Covered dependents

The following persons may be covered under your group's contract as your dependents.

1. Your lawful spouse.

2. Your dependent children including step- and adopted children. See the summary of benefits for child and student age limitations.

3. Unmarried dependent children who are full-time students at a high school, accredited school, college, or university. The number of hours required per semester for a full-time student is based on the school's definition, although this is generally 12 hours or more. Full-time students will not be covered under this plan when they are not attending school (i.e., if they take a semester off). Full-time students will not be covered during the summer if they do not resume school as a full-time student in the fall (unless your employer has determined otherwise).

4. Children dependent on you because of physical or mental incapacity.

5. Dependents no longer meeting the above requirements because of divorce or separation from an Eligible Employee, or the end of a child's dependency status may elect to continue coverage. See the Continued Coverage (COBRA) section of this handbook.

Effective dates of coverage

You are covered by your group's contract beginning on the first day the contract becomes effective or as determined by your group's contract. Your eligible dependents are covered beginning on the first day you become covered under your group's contract if you elect coverage for them. Changes in enrollment due to birth or adoption must be received by Delta Dental within 30 days of the birth or adoption. An eligible employee who waived coverage because he/she was covered under other insurance may elect coverage to be effective on the first day of the month following the loss of such other coverage. The eligible employee must apply for such change in coverage within 30 days of the event causing the loss of the other coverage.

Changes in coverage

You may change your enrollment in this dental plan if you experience a qualifying event such as a change in marital status, the acquisition of a dependent or the loss of coverage through your spouse's plan. The enrollment change will be effective the first of the month following the qualifying event. Notification of this enrollment change must be received by Delta Dental within 30 days of the qualifying event. The change in coverage must be consistent with the qualifying event. You may change your enrollment without a qualifying event if an open enrollment period is offered by the group. Elective coverage changes can be considered by Delta Dental only at that time. Notice to your employer or Delta Dental will be considered sufficient if mailed to each party's regular office address. Notices to you, as a subscriber, will be considered sufficient if mailed to your last known address or the last known address of your group. It is the responsibility of your group to notify you regarding changes or termination of your coverage.

Termination of coverage

Your coverage and that of your covered dependents ceases on the last day of the month in which you or your covered dependents are no longer eligible (check with your employer) or the day your group's contract is terminated. If you or your dependents lose eligibility under the plan, you or your dependents may elect to continue coverage as described in the Continued Coverage (COBRA) section of this handbook.

Qualified Medical Child Support Order (QMCSO)

If you have a dependent child and your employer receives a Medical Child Support Order recognizing the child's right to enroll in this benefit plan, your employer will promptly notify both you and the dependent that the order has been received. Your employer also will inform you and the dependent of the employer's procedures for determining whether the order is a Qualified Medical Child Support Order. Within a reasonable time after receiving the order, your employer will decide whether the court order is a qualified Medical Child Support Order and will notify you and the dependent of that determination.

Continued Coverage

This Group Health Plan is considered Non-ERISA and therefore not subject to COBRA. Your employer has voluntarily decided to offer Continuation of Coverage which is being referred to as COBRA throughout this document.

Qualifying event

A qualifying event allows an employee to make changes to their plan during the plan year. Examples of qualifying events are death, divorce, marriage, birth of a child, adoption, change in spouse's employment resulting in loss of coverage and loss of coverage under a parent's plan. You must notify your employer of the qualifying event. The notification needs to be made within 30 days of the event. Failure to notify your employer of this change within 30 days of the event may result in the change taking place at the employer's next open enrollment period.

Continued coverage for employees

Continued coverage is an option for employees if any of the following qualifying events occurs:
Termination of employment (voluntary or involuntary, except for reasons of gross misconduct) or reduction of hours.

Continued coverage for the spouse of an employee

Continued coverage for the spouse of an employee is an option if coverage is lost because any of the following qualifying events occur:

- Death of the spouse-employee.
- Termination of the spouse-employee's job for other than gross misconduct.
- Reduction of the spouse-employee's hours.
- Divorce or legal separation from the spouse-employee.
- Enrollment of the spouse-employee in Medicare.

Continued coverage for a dependent child

Children born to or adopted by an employee while the employee is on COBRA continuation coverage are eligible for COBRA continuation coverage as dependents of the employee. Continuation coverage for a dependent child of an employee is an option if any of the following qualifying events occur:

- No longer a dependent child as defined by this dental plan.
- Death of the parent-employee.
- Termination of the parent-employee's job for other than gross misconduct.
- Reduction of the parent-employee's hours.
- Divorce or legal separation of the parents.
- Parent-employee is enrolled in Medicare.
- The child is born to or adopted by the employee while the employee is on continued coverage.

Length of continued coverage

Your dental care coverage may continue according to the following schedule:

18 months:	If qualifying event is job termination or reduction of hours.
29 months:	For qualified beneficiaries who are totally disabled under Social Security either at the time of the qualifying event or during the first 60 days of COBRA continuation coverage.
36 months:	For all other qualifying events (including death, divorce and over age dependent).

Notification process

Your employer will advise Delta Dental if you lose coverage under this dental plan due to one of the qualifying events listed. You will be notified of your self-pay options and the dental plan's monthly costs. You will then have up to 60 days to decide whether to purchase continued coverage.

If your spouse or dependent child loses coverage due to one of the qualifying events listed, the person seeking the coverage extension must notify your employer. This individual will be informed of his or her self-pay options and will have 60 days from the qualifying event or notice of the qualifying event to decide whether to purchase the coverage.

Termination of continued coverage

Continued coverage following a qualifying event is a right provided by COBRA legislation. It is important to note, however, that continued dental coverage can be terminated for any of these reasons:

- An individual fails to make a timely premium payment.
- The employer ceases to offer a group dental plan.

Rights of Recovery (Subrogation)

Delta Dental has the right to recover claim payments made to you, or on your behalf, should you be compensated for damages by another party. (e.g., If you are in an accident and Delta Dental pays a claim for dental problems caused by the accident, we can request a refund from you if you receive compensation from the other party (or their insurance company) involved in the accident.)

Delta Dental's Liability

In no instance is Delta Dental liable for any conduct, including but not limited to negligence, or wrongful acts or omissions by any person, including but not limited to subscribers, dentists, dental assistants, dental hygienists, hospitals, or hospital employees receiving or providing services. In no instance is Delta Dental liable for services or facilities that, for any reason, are unavailable to you.

Appeals (Adverse Benefit Determination)

You have the right to appeal a denied claim or adverse benefit determination. Adverse benefit determinations are decisions Delta Dental make that results in denial, or reduction of the paid amount. Either you, your treating provider or an authorized representative appointed by you may file the appeal directly with us. You will be required to identify to Delta Dental in writing your authorized representative. Appeals must be received within 180 days of the original benefit determination and/or payment of the claim.

What can be appealed?

- Service(s) that Delta Dental did not approve.
- Service(s) that Delta Dental did not pay.
- Service(s) determined by Delta Dental not "medically necessary".

What cannot be appealed?

- How to apply your claim or services to your plan's deductible.
- The rate increase you may have received under your policy.
- The payment or authorization for services that are listed as not covered under your policy.
- When your lifetime or annual maximum benefit has been reached.

Customer service representatives are available during regular business hours to answer your questions. You can reach us at 1-877-841-1478. If the matter cannot be resolved to your satisfaction based on a telephone call, our internal appeals process is available to you. A representative will provide you with the necessary form to submit your appeal to us.

You or your authorized representative must file the appeal in writing and explain why you believe our decision was incorrect. Your appeal should include the following information:

- Name, address, and daytime telephone number;
- The subscriber identification number and group number (as shown on the ID card)
- The patient's name, address, and daytime telephone number; and
- The date of service, name and address of the dentist who provided the service.

You may submit written comments, documents, records, and other information relating to the claim even though we did not consider the information when making the initial decision. You may request and we will provide to you free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim.

We will conduct the appeal without deferring to the original adverse decision. The individual who conducts the appeal will not be the person who made the initial decision or that person's subordinate. We will consult a dental care professional who has appropriate training and experience in the field of dentistry if dental judgment is required. The dental care professional we consult for the appeal will not be the person we consulted in making the initial decision or that person's subordinate. Upon request, we will identify the dental professional we consulted, whether we relied on their advice in reaching our adverse decision.

Please send your request for appeal of an adverse benefit determination to:
Appeal Review
Delta Dental of South Dakota
PO Box 1157
Pierre, SD 57501

Grievances

If you are dissatisfied with the service received from your dental provider, we urge you to communicate directly with them. Providers welcome the opportunity to address your questions and concerns.

If you are not able to resolve your issues or concerns after having communicated with your provider, please call Delta Dental's customer service during regular business hours for assistance. If the customer service representative is unable to resolve your concerns to your satisfaction, you may file a grievance with us. A form will be provided to you by Delta Dental. Your grievance should include the following information:

- Name, address, and daytime telephone number;
- The subscriber identification number and group number (as shown on the ID card);
- A detailed written description of your concern so that we may fully understand and respond to it. Include any documentation you feel will help or support your concern.

Fax (605-494-2566) or mail your written grievance to:

Appeal Review
Delta Dental of South Dakota
PO Box 1157
Pierre, SD 57501

Delta Dental will send you a written determination within 30 days of receipt of your grievance. Submissions involving severe pain and/or imminent and serious threat to your health will be reviewed and responded to immediately.

You may also submit your grievance to the South Dakota Division of Insurance without first following Delta Dental's grievance process.

Division of Insurance
SD Department of Labor and Regulation
124 S Euclid Ave, Pierre, SD 57501
605-773-3563, Fax 605-773-5369
Email: sdinsurance@state.sd.us

HIPAA Notice of Privacy Practices

This section describes how health information about you may be used and disclosed and how you can get access to it. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of dental and claims records

- We will provide a copy or a summary of your dental and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- You can ask to see or get a copy of your dental and claims records and other information we have about you.

Ask us to correct dental and claims records

- You can ask us to correct your dental and claims records if you think they are incorrect or incomplete.
- We may say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we have shared information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- We will not retaliate against you for filing a complaint.
- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the US Department of Health and Human Services Office for Civil Rights.

  Visit: www.hhs.gov/ocr/privacy/hipaa/complaints/ or call 1-877-696-6775

  Write: 200 Independence Ave SW, Washington, DC 20201

Our Uses and Disclosures

We typically use or share your health information in the following ways:

We can help manage the dental care treatment you receive. We can use your health information and share it with professionals who are treating you.

We can run our organization. We can use and disclose your information to run our organization and contact you when necessary. Examples:

- We use health information about you to develop better services for you. In some instances, we do this by requesting that you complete a survey.
- We use health information about you to manage your treatment and services.

We can pay for your dental services. We can use and disclose your health information as we pay for your dental services. Example: We may use your information to bill your employer and to coordinate payment for your dental work if you have more than one insurance.

We can administer your plan. We may disclose your information to your employer for plan administration. Example: Your employer contracts with us to provide a dental plan, and we provide them with certain statistics to explain the premiums we charge.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information go to: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

We help with public health and safety issues. We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

We do research. We can use or share your information for health research.

We comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

We respond to requests and work with a medical examiner or funeral director.

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

We address workers' compensation, law enforcement, and other government requests. We can use or share health information about you:

- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions such as military, national security, and presidential protective services.

We respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Your Choices

For certain information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in the care and payment for your care.

Share information in a disaster relief situation.

If you are not able to tell us your preference, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing using an authorization form available on our website or by contacting us to request the form. If you tell us we can release information, you may change your mind at any time. Let us know in writing if you change your mind.
- To get a paper copy of this notice, contact Delta Dental's Privacy Officer. Contact information is available below.
- For more information about your protected health information visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the terms of this notice
We can change the terms of this notice, and the changes will apply to all information we have about you. We will post a copy of the current notice on our website www.deltadentalsd.com.

Contact for questions or complaints
If you have questions, concerns, or would like further information, please contact us at 877-841-1478 or compliance@deltadentalsd.com.

General Provisions

Incontestability clause -Time limit on certain defenses-Misstatements by applicant

Time limit on certain defenses: (1) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of such two-year period.

The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of §§ 58-17-32 to 58-17-39, inclusive, in the event of misstatement with respect to age or occupation or other insurance.

Non-disclosure

For the first two years from the effective date of this policy, any material misstatement, non-disclosure or concealment, whether or not such are innocent or fraudulent, in relation to any matter affecting this insurance shall render this policy void at our option.

Fraudulent claims

The making by the insured of any fraudulent claims shall render this policy null and void from the effective date and all claims under this policy shall be forfeited.

Clerical error

If a clerical error is made, it will not affect the insurance of any insured. No error will continue the insurance of an insured beyond the date it should end under this policy terms.

Conformity with state laws

On the effective date of this policy, any provision that conflicts with the laws in the state where it is issued is amended to conform to the minimum requirement of such laws.

Not in lieu of Workers' Compensation

This policy is not a Workers' Compensation policy. It does not provide Workers' Compensation benefits.