Delta Dental Medicare Advantage™ Dental Plan

Welcome!

Good oral health is a vital part of good general health, and your Delta Dental program is designed to promote regular dental visits. We encourage you to take advantage of this program by calling your Dentist today for an appointment.

This Member Handbook describes the specific benefits of your Delta Dental program and how to use them. If you have any questions about this program, please call our Customer Service department at 866-502-9753 (TTY Users call 711).

You can easily verify your own benefit, Claims and eligibility information online 24 hours a day, seven days a week by visiting www.deltadentalmn.org/myaccount and selecting the link for our Member Portal. The Member Portal will also allow you to print Claim forms, select paperless Explanation of Benefits statements (EOBs), search our Dentist directories, and read oral health tips.

We look forward to serving you!

Medicare Advantage Supplemental Dental Plan

Sanford Health Plan
Align Dual Partnership (HMO D-SNP)
Group Number - 700000
Subgroup Number - 4001

***Services received from dentists who do NOT participate in the Delta Dental Medicare Advantage Network will result in your out of pocket costs being higher.**

Benefit Year – January 1 through December 31

In-Network and Out-of-network preventive and comprehensive dental services can be covered using your Healthy Benefits+ Flex Card. Healthy Benefits+ Flex Card will provide you an annual $1,250 allowance for dental costs.

This section provides a list of dental procedures covered by your plan. If a procedure is not on this list, it is not a covered benefit under your plan. Benefit limitations under these programs are listed where applicable in the Benefit Limitations column. Some services share frequencies. Additional information on the frequency limitations can be found in this Member Handbook.

*Please note, certain procedures may require routine review or diagnostic information such as radiographs or patient treatment records for claims processing and final payment determinations. If further clarification regarding your coverage and benefits is needed, please ask your dentist for a Pre-Service Organization Determination.

It may be necessary for codes listed to be changed to comply with State, Federal, and American Dental Association (ADA) regulations. The ADA codes are subject to annual updates which may not be reflected in the provided list.

ADA Dental Code	Dental Procedure Description	Frequency
D0120	periodic oral evaluation - established patient	Twice per calendar year
D0140	limited oral evaluation - problem focused	As needed for diagnosis of emergency condition
D0150	comprehensive oral evaluation - new or established patient	Once per 3 year period
D0160	detailed and extensive oral evaluation - problem focused, by report	
D0180	comprehensive periodontal evaluation - new or established patient	Once per calendar year
D0190	screening of a patient	Once per calendar year
D0210	intraoral - complete series	Once per 5 year period
D0220*, D0230*, D0240* D0250*	intraoral/extra-oral - periapical image, occlusal image	Covered service
D0270, D0272, D0273, D0274, D0277	bitewing x-rays	Once per calendar year
D0330	panoramic image	Once per 5 year period
D1110	prophylaxis - adult	Twice per calendar year
D1354	Interim caries arresting medicament application – per tooth	Twice per calendar year
D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335,	amalgam and resin-based composite restoration, anterior and posterior	Amalgam and composite resin restorations are payable once in any two-year period by the same dentist, same tooth and same surface, regardless of the number or combination of restorations placed on a surface

D2390, D2391, D2392, D2393, D2394		
D2542, D2543, D2544	onlay - metallic	Once per 5 year period
D2642, D2643, D2644, D2662, D2663, D2664	onlay - porcelain/ceramic or resin-based	Once per tooth per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a metallic onlay
D2710*, D2712*, D2720*, D2721*, D2722*, D2740*, D2750*, D2751*, D2752*, D2753*, D2783*	crown - resin-based composite or porcelain ceramic	Once per tooth per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a full metal crown
D2780*, D2781*, D2782*	crown - 3/4 cast	Once per 5 year period
D2790*, D2791*, D2792*, D2794*	crown - full cast	Once per 5 year period
D2910*	re-cement or re-bond inlay, onlay or partial coverage restoration	Covered service
D2915*	re-cement or re-bond indirectly fabricated or prefabricated post and core	Covered service
D2920*	re-cement or re-bond crown	Covered service
D2921*	reattachment of tooth fragment, incisal edge or cusp	Covered service
D2928*, D2929*, D2930*, D2931*, D2932*, D2933*, D2934*	prefabricated crown	Covered service

D2940*	protective restoration	Once per tooth per lifetime and considered to be part of the fee when done in conjunction with a definitive restoration, indirect pulp cap or endodontic treatment (including pulpotomy)
D2950*	core buildup, including any pins when required	Once per tooth per 5 year period
D2951*	pin retention - per tooth, in addition to restoration	Once per tooth per lifetime
D2952*, D2954*	post and core in addition to crown	Once per tooth per 5 year period
D2980*, D2981*, D2982*	repair necessitated by restorative material failure	Covered service
D3220*	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	Covered service
D3221*	pulpal debridement, primary or permanent teeth	Covered service
D3222*	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	Once per tooth per lifetime; additional benefit will require review
D3230*, D3240*	pulpal therapy (resorbable filling) - any tooth (excluding final restoration)	Covered service
D3310*, D3320*, D3330*	endodontic therapy (excluding final restoration)	
D3332*	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	
D3333*	internal root repair of perforation defects	
D3346*, D3347*, D3348*	retreatment of previous root canal therapy	
D3351*, D3352*, D3353*	apexification/recalcification	
D3410*, D3421*, D3425*, D3426*	apicoectomy	
D3430*	retrograde filling - per root	
D3450*	root amputation - per root	
D3471*, D3472*, D3473*	surgical repair of root resorption	
D3501*, D3502*, D3503*	surgical exposure of root surface without apicoectomy or repair of root resorption	

D3920*	hemisection (including any root removal), not including root canal therapy	
D3921*	decoronation or submergence of an erupted tooth	Consultant review
D4210*, D4211*	gingivectomy or gingivoplasty	Once per 3 year period
D4240*, D4241*	gingival flap procedure, including root planing	
D4245*	apically positioned flap	
D4249*	clinical crown lengthening - hard tissue	Once per tooth per 2 year period
D4260*, D4261*	osseous surgery (including elevation of a full thickness flap and closure)	Once per 3 year period
D4263*, D4264*	bone replacement graft - retained natural tooth	
D4265*	biologic materials to aid in soft and osseous tissue regeneration	
D4266*, D4267*	guided tissue regeneration	
D4268*	surgical revision procedure, per tooth	
D4270*	pedicle soft tissue graft procedure	
D4273*, D4283*	autogenous connective tissue graft procedure	
D4274*	mesial/distal wedge procedure, single tooth	
D4275*, D4285*	non-autogenous connection tissue graft	
D4276*	combined connective tissue and double pedicle graft, per tooth	
D4277*, D4278*	free soft tissue graft procedure	
D4341*, D4342*	periodontal scaling and root planing	Once per 3 year period
D4346*	scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	Included in the cleaning frequency of twice per calendar year
D4355*	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	Once per lifetime; counts towards the cleaning frequency of twice per calendar year

D4910*	periodontal maintenance	Included in the cleaning frequency of twice per calendar year
D7140*	extraction, erupted tooth or exposed root (elevation and or forceps removal)	Once per tooth per lifetime
D7210*	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated	
D7220*, D7230*, D7240*	removal of impacted tooth	
D7241*	removal of impacted tooth - completely bony, with unusual surgical complications	
D7250*	removal of residual tooth roots (cutting procedure)	
D7251*	coronectomy - intentional partial tooth removal	
D7270*	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	Covered service
D7280*	exposure of an unerupted tooth	Once per tooth per lifetime
D7282*	mobilization of erupted or malpositioned tooth to aid eruption	
D7283*	placement of device to facilitate eruption of impacted tooth	Covered service
D7286*	biopsy of oral tissue - soft	Subject to services it is performed in conjunction with. Predetermination is strongly recommended.
D7288	brush biopsy – transepithelial sample collection	Covered service
D7290*	surgical repositioning of teeth	
D7291*	transseptal fiberotomy/supra crestal fiberotomy, by report	
D7310*, D7311*	alveoloplasty in conjunction with extractions - per quadrant	
D7320*, D7321*	alveoloplasty not in conjunction with extractions - per quadrant	

D7510*	incision and drainage of abscess - intraoral soft tissue	
D7511*	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	
D7910*	suture of recent small wounds up to 5 cm	
D7970*	excision of hyperplastic tissue - per arch	
D7971*	excision of pericoronal gingiva	
D9110	palliative (emergency) treatment of dental pain - minor procedure	As needed for diagnosis of emergency condition
D9120*	fixed partial denture sectioning	Covered service
D9222, D9223	deep sedation/general anesthesia	Paid in conjunction with qualifying services
D9239, D9243	intravenous moderate (conscious) sedation/analgesia	
D9310*	consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	Covered service
D9410*	house/extended care facility call	Requires consultant review
D9420*	hospital or ambulatory surgical center call	Requires consultant review
D9440	office visit – after regularly scheduled hours	As needed for diagnosis of emergency condition
D9930*	treatment of complications (post-surgical) – unusual circumstances, by report	Covered service
D9944, D9946	occlusal guard - hard appliance	Once per lifetime
D9951	occlusal adjustment - limited	Payable three times in a five-year period
D9952	occlusal adjustment - complete	Payable once in a five-year period

Definitions

Appeal

The procedures that deal with the review of adverse initial determination for payment of services.

Benefit Year

The calendar year.

Benefits

Payment for the Covered Services that have been selected under This Plan.

Completion Dates

The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- For dentures and partial dentures, on the delivery dates;
- For crowns and bridgework, on the permanent cementation date;
- For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Delta Dental

Delta Dental of Minnesota, Inc. is a nonprofit dental care corporation doing business as Delta Dental of Minnesota. Delta Dental is not an insurance company. Delta Dental of Minnesota, Inc. has been delegated by your Health Plan to provide dental benefits for This Plan.

Dental Emergency

A Dental Emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; Serious impairment to bodily functions; or Serious dysfunction of any bodily organ or part.

Dentist

A person licensed to practice dentistry in the state or jurisdiction in which dental services are performed.

- **Delta Dental Medicare Advantage Dentist -** a Dentist who has signed an agreement with Delta Dental for This Plan that is part of Delta Dental's Medicare Advantage Network.
- **Nonparticipating Dentist** – a Dentist who has not signed an agreement with Delta Dental to become part of the Delta Dental Medicare Advantage Network.

Grievance

An expression of dissatisfaction with any aspect of the operations, activities or behavior of Delta Dental, your MAO or a Dentist that has provided dental services under This Plan.

Member

A person with coverage under This Plan.

Member Handbook

Delta Dental will provide Benefits as described in this Member Handbook. Any changes in this Member Handbook will be based on changes to the contract between Delta Dental and your Medicare Advantage Organization (MAO).

This Plan

The dental coverage established for Eligible Persons pursuant to this Member Handbook.

Selecting a Dentist

To receive benefits under This Plan you must receive services from a Delta Dental Medicare Advantage Dentist.

To verify that a Dentist is a Medicare Advantage Participating Dentist, you can use Delta Dental's online Dentist Directory at www.deltadentalmn.org/find-a-dentist or call (866) 502-9753 (TTY Users call 711).

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. However, Medicare Advantage Participating Dentists may not charge Members for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the applicable prior dates of services in our records with any Delta Dental Plan or, at the request of your Medicare Advantage Organization, any dental plan.

NOTE: Not all Plans cover the services that may be noted below. Please reference the Covered Code List for the services your Plan covers.

1. Amalgam and composite resin restorations are payable once in any two-year period by the same dentist, regardless of the number or combination of restorations placed on a surface.
2. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
3. Recementation of a crown, onlay, inlay, or bridge within six months of the seating date.
4. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.
5. Root planing is payable once in any two-year period.
6. Periodontal surgery is payable once in any three-year period.
7. A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
8. Tissue conditioning is payable twice per arch in any three-year period.
9. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
10. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
11. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period when performed by the same office.
12. One assessment of salivary flow by measurement is allowed within a twelve (12) month period when done by the same Dentist/dental office.
13. Processing Policies may limit Delta Dental's payment for services or supplies.

Grievance and Appeals Procedures

If we make an Adverse Benefit Determination, you will receive a Notice of Denial of Coverage. You or your authorized representative, should seek a review as soon as possible, but you must file your request for review within **60 days** of the date that you received that Notice of Denial of Coverage. Delta Dental may give you more time if you have a good reason for missing the deadline.

There are two types of appeals.

Standard Appeal – We will give you a written decision on a standard appeal within 30 days after we get your appeal for a Pre-Service Organization Determination. Our decision might take longer if you ask for an extension, or if we need more information about your case. We will tell you if we are taking extra time and will explain why more time is needed. If your appeal is for payment of a service you have already received, we will give you a written decision within 60 days.

Fast Appeal – We will give you a decision on a fast appeal within 72 hours after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 Days for a decision. You cannot request a fast appeal if you are asking us to pay you back for a service you have already received.

Send appeals to the following:

Delta Dental
Attn: Professional Services Appeals
PO Box 30416
Lansing, MI 48909

Phone: (866) 502-9753

TTY: 711

Please include your name and address, the Member ID, the explanation of benefits, the reason why you believe your claim was wrongly denied, and any other information you believe supports your claim. Indicate in your letter that you are requesting a formal appeal (Standard/Fast Appeal) of your claim. You also have the right to review any documents related to your appeal. If you would like a record of your request and proof that Delta Dental received it, mail your request certified mail, return receipt requested.

If you want someone else to act for you, you can name a relative, friend, attorney, dentist or someone else to act as your representative. You can do this by following the authorized representative section above. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You will need to mail or fax the statement to Delta Dental.

The Dental Director or any person reviewing your claim will not be the same as, nor subordinate to, the person(s) who initially decided your claim. The reviewer will grant no deference to the prior decision about your claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to your claim even if the information was not available when your claim was initially decided.

The notice of any adverse determination regarding your appeal will

(a) inform you of the specific reason(s) for the denial,

(b) list the pertinent Plan provision(s) on which the denial is based,

(c) contain a description of any additional information or material that is needed to decide the claim and an explanation of why such information is needed,

(d) reference any internal rule, guideline, or protocol that was relied on in making the decision on review.

Adverse appeals will be automatically submitted to the CMS's contracted independent review entity within 60 calendar days from the date Delta Dental received the member's first level appeal. The Appeals Staff will concurrently notify the member that the appeal is being forwarded to CMS's independent review entity.

If you have a complaint or dispute, other than a Notice of Denial of Coverage, expressing dissatisfaction with the manner in which Delta Dental or a dentist has provided dental services, you can contact Delta Dental at the address listed above in this section or call customer service at (866) 502-9753 within 60 days of the event. Delta Dental will respond in writing to all Grievances within 30 days of receipt, unless issue is resolved by customer service on the call.

Termination of Coverage

Your Delta Dental coverage may automatically terminate:

- When your Health Plan advises Delta Dental to terminate your coverage.
- On the first day of the month for which your Health Plan has failed to pay Delta Dental.
- For fraud or misrepresentation in the submission of any claim.
- For any other reason stated in the contract between Delta Dental and your Health Plan.

Delta Dental will not continue eligibility for any person covered under This Plan beyond the termination date requested by your Health Plan. A person whose eligibility is terminated may not continue coverage under this Member Handbook.

Delta Dental's obligation for payment of Benefits ends on the last day of coverage. This date is usually the first of the month following receipt of a valid, written request to disenroll that was accepted by your plan during a valid Medicare election period. However, Delta Dental will make payment for Covered Services provided on or before the last day of coverage, as long as Delta Dental receives a Claim for those services within one year of the date of service.

General Conditions

Subrogation and Right of Reimbursement

If Delta Dental provides Benefits under This Plan and you have a right to recover damages from another, Delta Dental is subrogated to that right.

To the extent that This Plan provides or pays Benefits for Covered Services, Delta Dental is subrogated to any right you or your Eligible Dependent has to recover from another, his or her insurer, or under his or her "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions. You or your legal representative must do whatever is necessary to enable Delta Dental to exercise its rights and do nothing to prejudice them.

If you recover damages from any party or through any coverage named above, you must reimburse Delta Dental from that recovery to the extent of payments made under This Plan.

Obtaining and Releasing Information

While you are an Eligible Person, you agree to provide Delta Dental with any information it needs to process your claims and administer your Benefits. This includes allowing Delta Dental access to your dental records.

Dentist-Patient Relationship

Eligible Persons are free to choose any Dentist. Each Dentist maintains the dentist-patient relationship and is solely responsible to the patient for dental advice and treatment and any resulting liability.

Loss of Eligibility During Treatment

If an Eligible Person loses eligibility while receiving dental treatment, only Covered Services received while that person was covered under This Plan will be payable.

Certain services begun before the loss of eligibility may be covered if they are completed within 60 days from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. The difference between Delta Dental's payment and the total fee for those services is your responsibility.

Change of Member Handbook or Contract

No agent has the authority to change any provisions in this Member Handbook or the provisions of the contract on which it is based. No changes to this Member Handbook or the underlying contract are valid unless Delta Dental approves them in writing.

Actions

No action on a legal claim arising out of or related to this Member Handbook will be brought within 60 days after notice of the legal claim has been given to Delta Dental, unless prohibited by applicable state law. In addition, no action can be brought more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, if longer. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude you from seeking a judicial decision or pursuing other available legal remedies.

Right of Recovery Due to Fraud

If Delta Dental pays for services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a claim that contains false or misrepresented information, or pays a claim that is determined to be fraudulent due to your acts or acts of your Eligible Dependents, it may recover that payment from you or your Eligible Dependents. You and your Eligible Dependents authorize Delta Dental to recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you or your Eligible Dependents. Delta Dental will provide an explanation of the payment recovery at the time the deduction is made.

Governing Law

This Member Handbook and the underlying group contract will be governed by and interpreted under the Centers for Medicare and Medicaid Services (CMS)

Legally Mandated Benefits

If any applicable law requires broader coverage or more favorable treatment for you or your Eligible Dependents than is provided by this Member Handbook, that law shall control over the language of this Member Handbook.

Sanctioned and/or Precluded Providers

If you choose to receive services from a Nonparticipating dentist, be sure to ask the dentist if they are excluded from the Medicare program. Delta Dental is unable to make payment to either you or your dentist for any services received from a provider that has been excluded from Medicare.

Any person intending to deceive an insurer, who knowingly submits an application or files a claim containing a false or misleading statement, is guilty of insurance fraud.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call our toll-free hotline. We only accept anti-fraud calls at this number.

ANTI-FRAUD TOLL-FREE HOTLINE:

800.524.0147

Sanford Health Plan and Sanford Health Plan of Minnesota have HMO and PPO plans with a Medicare contract. Sanford Health Plan D-SNPs have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. Sanford Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, or any other classification protected under the law. This information is not a complete list of benefits. Limitations, copayments, and restrictions may apply Call (888) 278-6485 (TTY: (888) 279-1549) from 8 a.m. to 8 p.m. CST, 7 days a week for more information.

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