PREPAID DENTAL PLANS
GROUP COVERAGE

SUMMARY OF COVERAGE
&
CERTIFICATE OF BENEFITS

Teton County

Group #70025

Delta Dental of Wyoming
6234 Yellowstone Rd
P.O. Box 29
Cheyenne, WY 82003-0029
(307) 632-3313
(800) 735-3379

GROUP DENTAL BENEFITS
CERTIFICATE OF COVERAGE
DELTA DENTAL PLAN OF WYOMING
A WYOMING NONPROFIT CORPORATION
D.B.A. DELTA DENTAL OF WYOMING
(Hereinafter called Delta Dental)

Delta Dental HEREBY CERTIFIES that the individual given this certificate is covered under the Group provided the individual is eligible for such coverage and premiums are paid to Delta Dental by the Group on behalf of such individual. The benefits described herein are subject to all the provisions, terms and conditions of the Contract. The Contract alone constitutes the entire Contract under which rights and benefits are provided. A copy of the Contract is on file with your Group. Capitalized terms have the same meaning here as in the Contract.

DELTA DENTAL OF WYOMING

ELIGIBILITY

I. Definitions

Eligible Employee means a full-time (as defined in the Contract), permanent employee of the covered group who has been employed full-time by the employer for the Eligibility Waiting Period and for whom the required enrollment form has been completed and forwarded by the Group with the required periodic premium payments to Delta Dental of Wyoming. An employee is not eligible while on active military duty if that duty exceeds a period of thirty-one (31) consecutive days.

Eligible Dependent means an Eligible Employee's legal spouse and unmarried children, including adoptive children, stepchildren or foster children, a child whom you are the legal guardian, of a child for whom the plan has received a Qualified Medical Child Support Order requiring a covered employee to provide health coverage, and a child who resides with the Eligible Employee and who is dependent on such Employee for support and maintenance and meets the requirements established by the Internal Revenue Service to be a qualified dependent. Eligible children are covered through the end of the month that age twenty-six (26) is attained. Mentally or physically disabled children shall be considered Eligible Dependents for dental coverage regardless of age. Proof of capacity must be furnished upon request, and additional proof may be required from time to time. *Dependents in the military service are NOT ELIGIBLE.*

II. Coverage Period

An Eligible Employee becomes covered on the first day of the month following the Eligibility Waiting Period of continuous full-time employment and remains eligible for the effective contract period.

Eligible Dependents, if enrolled, are eligible on the date the Employee's coverage is effective or on the first day of the month following the date on which the Employee acquires the dependent, whichever later occurs.

Eligible Dependents not enrolled on the day the Employee becomes eligible or within 31 days of their becoming an Eligible Dependent, are subject to Delta Dental's underwriting policies for late enrollment, which may include providing Delta Dental with Evidence of Insurability or upon renewal at Delta Dental's discretion.

Coverage for the Employee and/or Eligible Dependent shall terminate on the last day of the month in which: (1) the individual ceases to meet the definition of eligibility above, or (2) the required periodic premium is not received by Delta Dental from the covered group, whichever first occurs.

Employees and/or dependents that enroll and withdraw from this plan for any reason will not be allowed to re-enroll for a period of three years. The only exception is if an Employee enrolls for dependent coverage and later drops that coverage because his dependents become covered under another group plan sponsored by the Employee's spouse's employer. If such coverage is later terminated under the same circumstances, the Employee will be allowed to re-enroll his dependents for coverage without waiting the full three years otherwise required under this plan.

III. Coverage After Termination

If an Employee's coverage terminates while he is receiving treatment under a predetermination or preauthorization of benefits which was approved while he was eligible for benefits, benefits will not continue to be paid for such approved treatment.

Employees and dependents who have been terminated, voluntarily or involuntarily, the dependents of an Employee upon the Employee's death and Employees in certain other situations may be entitled to an extension of Benefits under "COBRA" at the employee's expense. (Ask your employer for complete details of Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or other State or Federal continuation of coverage statutes and/or regulations. Also contact your employer to determine if the American Recovery and Reinvestment Act of 2009 (ARRA Pub. L. 111-5), provides you with a reduction in the amount of premium paid by you under COBRA.)

BENEFITS

I. Benefit Percentage

Benefit Percentage is the percentage of allowable expenses that the plan will pay for services rendered.

For Diagnostic and Preventive Services........................100%
For Basic Services..80%
For Major Services..50%
Maximum Benefit Per Person Per Benefit* Year $1,500

For Orthodontic Services..50%
$1,000 Maximum Lifetime Orthodontics Per Eligible Person

II. Deductible

Deductible is the amount of covered dental expenses which the patient pays before the dental benefits are payable, and applies to each covered person per Benefit* Year.

Deductible Per Person..$25

Deductible Per Family..$50

Diagnostic & Preventive Services are NOT subject to the deductible.

III. Maximum Benefit

Maximum Benefit is the total dollar amount that the Plan will pay for services rendered during any one year and applies to each covered person per Benefit* Year.

*See the master contract or your benefit representative or call Delta Dental to define your benefit year (either contract or calendar).

IV. Payment Procedures

A. Delta Dental shall pay the Participating Dentist's usual, customary and reasonable fees up to the 90th percentile as determined by Delta Dental from fees filed and/or charged by Wyoming Dentists, or the fees actually charged, whichever is less.

B. The amounts payable by Delta Dental with respect to the services rendered by a Non-Participating Dentist shall not exceed the least of the dentist's fees, the prevailing fee or the 51st percentile, as determined by Delta Dental.

C. The amounts payable by Delta Dental with respect to services rendered by a dentist in another state or country who is not a Participating Dentist of Delta Dental in that state shall not exceed the amount that would be payable if such services had been provided by a Participating Dentist in Wyoming.

D. The amounts payable by Delta Dental with respect to services rendered by a dentist in another state who is a Participating Dentist of a Delta Dental Plan in that state shall be those that would be payable by that other Delta Dental Plan.

COVERED DENTAL SERVICES

Delta Dental will cover the following Services when they are rendered by a licensed dentist and when necessary and customary, as determined by the standards of generally accepted dental practice:

I. Diagnostic & Preventive Services

A. Diagnostic: The necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment.

B. Preventive: The necessary procedures to prevent the occurrence of oral disease. These services (subject to "**Limitations**" and "**Exclusions**" hereafter) include:

1. Exams and/or prophylaxis (cleaning) and bitewing x-rays at six (6) month intervals (not to exceed two in one year).
2. Full mouth x-rays once in a thirty-six (36) month period are a payable benefit separately or in conjunction with other diagnostic x-rays.
3. Topical application of fluoride solutions for dependent children once every twelve (12) months (through the end of the month that age nineteen (19) is attained).
4. Space maintainers for primary teeth to preserve existing space (through the end of the month that age nineteen (19) is attained).
5. Sealants for dependent children on posterior permanent teeth (through the end of the month that age nineteen (19) is attained).

II. Basic Services

A. Oral Surgery, including (a) extractions, (b) cutting procedures in the mouth, (c) treatment of fractures and dislocations of the jaw.

B. General anesthetics and their administration by an oral surgeon or when proven medically necessary.

C. Restorations for treatment of teeth with carious lesions or injury, including synthetic and amalgam fillings.

D. Emergency treatment for relief of pain.

E. Periodontics treatment of the gums and supporting structures of the teeth.

F. Root canal therapy and other endodontic treatment.

III. Major Services

A. Prosthodontics: The necessary procedures for repair or construction of bridges, partial and complete dentures.

1. Partial Dentures: Delta Dental will provide a standard cast metal or acrylic partial denture or will allow the cost of such procedure toward a more complicated or precision appliance that patient and dentist may choose to use.

2. Complete Dentures: If in the construction of a denture the patient and dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, Delta Dental will allow an appropriate amount for the standard denture toward such treatment and the patient must bear the difference in cost.

B. Restorative Crowns & Onlays: The necessary procedures for provision of crowns, jackets or onlays (except stainless steel crowns which are covered under Basic Services) when teeth cannot be restored with amalgam, composite resin or plastic materials due to extensive caries or fractures. An x-ray must accompany all claims for crowns. Crowns are not a benefit for cosmetic, attrition or preventive reasons.

C. Dental Implants: The necessary procedures for implants including the crown, bridge or denture over the implant.

IV. Orthodontic Services

A. Orthodontic diagnostic procedures (including cephalometric x-rays).

B. Surgical therapy (surgical repositioning of the jaw, facial bones and/or teeth to correct malocclusion).

C. Appliance therapy (braces) including oral exams, surgery, extractions and x-rays.

D. Available only for unmarried, dependent children (through the end of the month that age nineteen (19) is attained).

LIMITATIONS

The benefits as outlined in all Plans are subject to the following limitations:

A. Diagnostic: Exams and bitewing x-rays are a benefit once in a six (6) month period (not to exceed two in one year). Full mouth x-rays are a benefit once in a thirty-six (36) month period and are a payable benefit separately or in conjunction with other diagnostic x-rays.

B. Preventive: Prophylaxis is a benefit once every six (6) months (not to exceed two in one year). Topical fluoride applications for dependent children are a benefit once every twelve (12) months (through the end of the month that age nineteen (19) is attained). Space maintainers are a benefit only to maintain space of primary teeth (through the end of the month that age nineteen (19) is attained). Sealants for dependent children on posterior permanent teeth are a benefit once in a three (3) year period (through the end of the month that age nineteen (19) is attained). Teeth must be without caries or restorations, with the occlusal surface intact.

C. Restorative: Synthetic restorations (composites) on posterior teeth are a benefit.

D. Prosthodontic appliances (including bridges, partial and complete dentures), cast crowns, jackets and cast restorations will be replaced only after five (5) years have elapsed following any prior placement of such appliances under any Delta Dental program.

E. Interim (surgical or temporary) dentures are considered optional services and are not a benefit.

F. Replacement will be made of an existing prosthodontic appliance only if it is unsatisfactory and cannot be made satisfactory.

G. Porcelain or metallic inlays and veneers are considered optional, and as such, are not covered services.

H. Fixed bridges and/or removable partials are not a benefit for children under age sixteen (16). An allowance will be made for a temporary acrylic partial.

I. A fixed bridge is not a covered service when done in connection with a removable partial denture in the same arch.

J. Cast crowns, veneer crowns and jackets are not covered services for children under age sixteen (16). An allowance will be made for an acrylic crown or a preformed stainless steel crown.

K. Reline or rebase of a denture is a benefit only twice in a five (5) year period.

L. Optional services: In all cases in which the patient selects a more expensive plan of treatment than is customarily provided, Delta Dental will pay the applicable percentage of the lesser fee. The patient is responsible for the remainder of the dentist's fee. In the event the treatment of choice is NOT a benefit of the plan, the patient is responsible for the dentist's fee.

EXCLUSIONS

Delta Dental **excludes** the following services:

A. Services rendered before the date the Insured Person's dental coverage starts.

B. Any procedure which is covered by your medical, automobile or liability coverage must be submitted to that carrier first and any balance not paid, up to the amount allowed by Delta Dental will be paid at the appropriate co-payment subject to the deductible.

C. Services in excess of any limitation specified in the list of **"Covered Dental Services"** on pages 4-6.

D. Dental or surgical procedures performed to correct developmental malformation, acquired malformation or for cosmetic reasons.

E. Diet planning or training in oral hygiene or preventive care.

F. Replacement of a Prosthesis which can be repaired or does not need repair.

G. Replacement of a Prosthesis within five (5) years after it was first placed, except when the replacement is: (1) made necessary by the extraction of a functioning natural tooth which is replaced and the existing Prosthesis cannot be made serviceable; or (2) for full or partial dentures which, while in the mouth, have been damaged beyond repair as a result of injury occurring while insured.

H. Replacement of a lost, stolen or broken appliance.

I. Splinting (the joining of teeth to support each other) for periodontal reasons (stabilization) by crowns or other means. Splinting for stabilization due to an accident or injury is a covered benefit.

J. Any procedure which: (1) is for the purpose of changing vertical dimension; or (2) relates to bite registration, bite analysis, or the correction of the bite;

or (3) is for replacing tooth structure lost as a result of abrasion or attrition; or (4) is for equilibration or restorations for malalignment of the teeth; or (5) gnathologic recordings.

K. The removal and/or maintenance of implants.

L. Cosmetic dentistry, acid etch, laminates, bite guards, athletic mouthguards, precision or semi-precision attachments.

M. Treatment of Temporomandibular Joint Dysfunction.

N. Pre-medication, analgesia or conscious sedation.

O. Costs incurred for failure to keep a scheduled visit with a Dentist or for completing insurance forms.

P. General anesthesia except when administered for a covered oral surgery procedure performed by a dentist when medically necessary.

Q. Services for which the Insured Person has or had a right to payment under: (1) a workers' compensation or similar law; or (2) a program of a government or plan established by law, except: (a) Medicare; (b) Medicaid; (c) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and (d) where the law does not permit this type of exclusion.

R. Orthodontic services, unless described under **"Covered Dental Services"** on pages 4-6.

S. Sterilization Preparation, Infection Control, Operatory Preparation and Sepsis Control are considered part of all procedures and are NOT covered services.

T. Prescription drugs and relative analgesia.

U. Charges for hospital services or hypnosis.

V. Injection of antibiotic drugs.

W. Delta Dental shall not be obligated to pay claims submitted more than twelve (12) months after the date of the service.

COORDINATION OF BENEFITS

The purpose of this plan is to assist in meeting the cost of needed dental care or treatment. However, a plan cannot pay for every procedure that may be needed. It is not intended that anyone receive benefits greater than the actual expenses incurred. Benefits payable by this Plan and any other group dental or medical plan will be coordinated so that the total benefits allowed will not exceed 100% of the covered dental expenses. In no event will payment under this Plan exceed the amount which **would have been allowed** if no other plan(s) were involved. All benefits provided herein are subject to this provision.

HOW DOES THE PROGRAM WORK?

Visit the dentist of your choice. If you do not have a dentist, select the one you wish and call either his office or Delta Dental to determine if he is a Participating Dentist. A list of Participating Dentists will be provided for reference if requested.

During your first appointment, advise your dentist that you are covered by Delta Dental under the Contract number of your plan and give the dentist your Social Security Number. DEPENDENTS MUST USE THE EMPLOYEE'S SOCIAL SECURITY NUMBER. After an examination, your dentist will determine the treatment needed. If extensive services of $250 or more are needed, your dentist may complete a treatment form to provide a predetermination or preauthorization of benefits.

Submit the form to:

Delta Dental of Wyoming
6234 Yellowstone Rd
P.O. Box 29
Cheyenne, Wyoming 82003-0029
(307) 632-3313
(800) 735-3379

Delta Dental will verify your eligibility and determine the amount of benefit to be paid by your Plan. The treatment form will be returned to the dentist by Delta Dental. The total amount of the dentist's fee, the amount of benefit to be paid by Delta Dental and the portion you are required to pay will be shown thereon and *should be discussed with the dentist before the extensive treatment begins.*

I. The Participating Dentist

The Participating Dentist, under contract with Delta Dental, will agree to the following provisions (see **"Payment Procedures"** on page 4): (1) to file claim form(s) directly with Delta Dental (you must fill out the patient information); (2) not to charge the patient up front any amount covered by Delta Dental except deductible and co-payment; (3) if the dentist chooses he may charge the patient at the time of service for any procedure not covered by Delta Dental (see **"Limitations"** and **"Exclusions"** on pages 6-8); (4) not to charge back to the patient (balance bill) any amount over the amount allowed by Delta Dental; (5) that all payments are to be made directly to the Participating Dentist.

II. The Non-Participating Dentist

If your dentist is a Non-Participating Dentist (a dentist who has not signed an agreement with Delta Dental), payment will be based upon the 51st percentile which may be lower than for a Participating Dentist as explained on page 4 under

"**Payment Procedures.**" You will be responsible to the Non-Participating Dentist for the full cost of treatment and Delta Dental will reimburse you for the amount of benefit payable by your Plan. The Non-Participating Dentist has no obligation to abide by the additional provisions agreed to by a Participating Dentist listed above.

THE IMPORTANCE OF PREDETERMINATION OR PREAUTHORIZATION OF COSTS

Predetermination or preauthorization of benefits is recommended for all dental care in the amount of $250 or more.

Predetermination or preauthorization (submission of a treatment form in advance of performing services) removes the guesswork in determining what the Plan will pay for the services, and thereby eliminates possible confusion and misunderstanding between the dentist and the patient.

Details involving co-payment, deductibles or maximums related to the program are clarified by predetermination or preauthorization and prescribed services covered under the terms of the contract are known in advance of treatment.

This permits both employee and dentist to be aware of their responsibilities with respect to payment for services prior to the start of treatment.

Predetermination or preauthorization does not guarantee payment. Estimated Delta Dental payment is based on each patient's current eligibility and contract benefits. Submission of other claims or changes in eligibility or the contract may alter the final payment amount.

QUALITY DENTAL CARE

This dental program recognizes the right of each Employee or Dependent to select a dentist of his or her own choosing. Neither the Contract Holder nor Delta Dental assumes any responsibility for the selection of dentists or for the quality of care by such dentists.

QUESTIONS OR CONCERNS

Delta Dental will, in conjunction with a proper review committee, research the circumstances surrounding your concern and make a written reply to you. Employees who have questions relating to eligibility or benefits are requested to contact Delta Dental by phone or in writing. Concerns should be submitted in written form to the Dental Director.

Dental Director, Delta Dental of Wyoming

6234 Yellowstone Rd

P.O. Box 29

Cheyenne, Wyoming 82003-0029

CLAIMS INQUIRY

A toll-free number is available for your use in calling Delta Dental from locations outside the Cheyenne area to inquire about claims or a specific doctor's membership status. This number is 1-800-735-3379. Cheyenne area calls should be made to 632-3313.

THIS CERTIFICATE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE DENTAL PLAN. THE DENTAL PLAN CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.

Revised November 2012

Delta Dental

Delta Dental of Wyoming

AMENDMENT TO THE DENTAL BENEFIT PLAN SUMMARY

This amendment modifies your Dental Benefit Plan Summary and is effective December 1, 2011.

Your Dental Benefit Plan Summary shall be amended to include the following:

DELTA DENTAL OF WYOMING
NOTICE OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions concerning this notice, please contact:
Privacy Officer
Delta Dental of Wyoming
6234 Yellowstone Rd/PO Box 29
Cheyenne, WY 82003

307-632-3313/800-735-3379

Delta Dental of Wyoming (the "Plan") is required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information and we are committed to protecting the privacy and confidentiality of your health and personal information.

HOW THE PLAN MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Uses and Disclosures of Protected Health Information Without Your Specific Authorization

The Plan may use and disclose your health information about you for payment or health care operations without any consent or authorization beyond your enrollment in the Plan.

Payment means activities related to the Plan's payment to pay you or your health care provider for covered expenses. Activities associated with payment include, but are not limited to, enrollment activities; collection of contributions from you and your employer; payment for covered expenses, including coordination of benefits; review of payment decisions upon appeal; activities related to pre-authorization of benefits and utilization review; and disclosure of contribution payment history to a consumer reporting agency.

Health Care Operations means activities undertaken to administer your program including, but not limited to, activities necessary to reduce overall health care costs; contacting you or your health care provider about alternative treatments; evaluating practitioner and provider performance; training of non-health care professionals; activities related to obtaining an insurance contract, such as census rating for premiums; conducting or arranging for claims review, legal services, and auditing functions; fraud and abuse detection and compliance-related activities; analysis related to managing and operating the Plan; development or change of payment methods or coverage policies; and educational activities.

Under applicable federal law, there are other uses and disclosures the Plan may make without your specific authorization.

Disclosures of Protected Health Information to the Plan Sponsor. The Plan will disclose protected information only to the minimal extent it helps your employer administer the program, such as providing billing information, and confirmation of enrollment. The employer must limit its use of that information to obtaining quotes or modifying, amending, or terminating the Plan.

Creation of de-identified health information. The Plan may use your protected health information to create de-identified health information. This means that all data items that would help identify you, such as name, address, birth date, and hire date are removed or modified. Once information is de-identified it is no longer protected.

You may request in writing that we not use or disclose your PHI for treatment, payment and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations, if you clearly state that disclosure of all or part of your PHI could endanger you.

COMPLAINTS

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Disclosures for health oversight activities. The Plan may disclose your protected health information to a health oversight agency for oversight activities to complete applicable audits, investigations or inspections.

Disclosures for judicial and administrative proceedings. Your protected health information may be disclosed during any judicial or administrative proceeding as required by appropriate administrative or judicial court proceedings.

Disclosures for law enforcement purposes. We may disclose your protected health information to a law enforcement official as required by law or to comply with a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer.

Disclosures regarding victims of a crime or to avert a serious threat to health or safety. In response to a law enforcement official's request, the Plan may disclose information about you with your approval or in an emergency situation and you are incapacitated, or if it appears you were the victim of a crime. We may also disclose your protected health information to prevent or lessen a serious and imminent threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

Disclosures for specialized government functions. The Plan may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

Uses and Disclosures Requiring Your Authorization. All other uses and disclosures of your health information, including family members or any other individual not already authorized to receive protected health information, will be made by the Plan only with your express written authorization. If you provide authorization for any use or disclosure of your protected health information, you may revoke that authorization, in writing, at any time. The revocation will not apply to any previous use or disclosure.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

Right To Inspect and Copy. You have the right to inspect and copy health information collected and maintained by the Plan. To inspect and copy your health information, you must complete a specific form providing information needed to process your request from the Privacy Officer at the address identified on this Notice and you may be charged a fee to cover expenses associated with your request.

Right To Amend Incorrect or Incomplete Information. You may request that Plan change your health information, although we are not required to do so. If your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make your request in writing. You must also provide a reason for your request.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you, with certain exceptions specifically defined by law. To request this list or accounting of disclosures, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the person identified on the first page of this Notice.

Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice.

Right to Request Alternative Methods of Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request an alternative method of communications, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the person identified on the first page of this Notice. You may obtain a copy of this notice at our website, www.deltadentalwy.org

COMPLAINTS

If you believe your rights with respect to health information about you have been violated by the Plan, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the person identified on the first page of this Notice. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

The effective date of this Notice is December 1, 2011. The Plan reserves the right to change the terms of this notice and to make the revised notice effective with respect to all protected health information regardless of when the information was created. If the notice is revised, the new notice will be provided to you, if you are still covered by the Plan, either through e-mail or U.S. postal service, within sixty days of such revision. Otherwise, we will provide you once every three years a reminder of the availability of this Notice and how to obtain the Notice.

The Claim Appeal Procedures portion of your Dental Benefit Plan Summary shall be deleted in its entirety and replaced with the following:

Claim and Appeal Procedure Claim and Appeal Procedures:

Initial Claim Determinations

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

Appeals

In the event that we deny a claim in whole or in part, you have a right to a full and fair review. Your request to review a claim must be in writing and submitted within 180 days from the claim denial. We will make a benefit determination within 60 days following receipt of your appeal. In unusual cases, such as those which require review by a dentist, the review may take longer than the initial 60-day period. In such cases, written notice of the extension shall be furnished to you prior to the termination of that period. In no event will an extension exceed 60 days from the end of the initial 60-day period.

Your appeal must include your name, your identification number, group number, claim number, and dentist's name as shown on the Explanation of Benefits. Send your appeal to the address shown on the Explanation of Benefits. You may submit written comments, documents, or other information in support of your appeal. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim (whether or not presented or available at the initial determination) and the initial determination will not be given any weight.

The review will be conducted by someone different from the original decision makers and without deference to any prior decision. Because all

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

Authorized Representative

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

All other terms and conditions of the Dental Benefit Plan Summary shall remain in full force and effect.

DELTA DENTAL OF WYOMING

Notes

Notes

Delta Dental of Wyoming
6234 Yellowstone Rd
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