HealthPartners®

Summary of Benefits

HealthPartners State of Minnesota Dental Plan

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Specific Information About The Plan

Summary of Benefits Effective Date: The later of January 1, 2017 or the covered person's effective date of coverage under the Plan.

Employer:	State of Minnesota
Name of the Plan:	The Plan shall be known as the HealthPartners State of Minnesota Dental Plan which provides employee and dependent dental benefits.
Address of the Plan:	State of Minnesota Minnesota Management and Budget Employee Insurance Division 400 Centennial Office Building 658 Cedar Street, St Paul MN 55155
Group Number:	3080
Plan Year:	The plan year begins on January 1.
Plan Fiscal Year Ends:	December 31
Plan Sponsor: (is ultimately responsible for the management of the Plan; may employ or contract with persons or firms to perform day-to-day functions such as processing claims and performing other Plan-connected services.)	State of Minneosta Minnesota Management and Budget Employee Insurance Division
Agent for Service of Legal Process:	Julie Sonier, Director Minnesota Management and Budget Employee Insurance Division 400 Centennial Office Building 658 Cedar Street St. Paul, MN 55155
Named Fiduciary: (has the authority to control and manage the operation and administration of the Plan; has discretionary authority to determine eligibility for benefits or to construe the terms of the Plan.)	State of Minnesota Minnesota Management and Budget Employee Insurance Division
Funding:	Claims under the Plan are paid from the assets of a trust of the Employer.
Claims Administrator: (provides administrative services to the Plan Sponsor in connection with the operation of the Plan, such as processing of claims and other functions, as may be delegated to it.)	HealthPartners Administrators, Inc. 8170 33rd Avenue South, P.O. Box 1309 Minneapolis, MN 55440-1309 952-883-7900/888-343-4404 (toll-free) TTY: 952-883-5127/888-850-4762 (toll-free)
Network Providers:	HealthPartners Network
Contributions:	Please refer to the most recent enrollment material for information regarding contributions to your Plan which is hereby incorporated by this reference.

HEALTHPARTNERS MISSION

TO IMPROVE HEALTH AND WELL-BEING IN PARTNERSHIP WITH OUR MEMBERS, PATIENTS AND COMMUNITY.

About HealthPartners and MMB

HealthPartners Administrators, Inc. ("HPAI"). HPAI ("Claims Administrator") is a third party administrator (TPA) which is a related organization of HealthPartners, Inc.

HealthPartners, Inc. ("HealthPartners"). HealthPartners is a Minnesota non-profit corporation and managed care organization.

MMB ("Plan Sponsor"). MMB has established a Dental Benefit Plan ("the Plan") to provide dental benefits for covered employees and their covered dependents ("covered persons"). The Plan is "self-insured" which means that the Plan Sponsor pays the claims from its own funding as expenses for covered services as they are incurred. The Plan is described in the Summary of Benefits ("SB"). The Plan Sponsor has contracted with HPAI to provide access to its network of dental care providers, claims processing, pre-certification and other Plan administration services. However, the Plan Sponsor is solely responsible for payment of your eligible claims.

Powers of the Plan Sponsor. The Plan Sponsor shall have all powers and discretion necessary to administer the Plan, including, without limitation, powers to: (1) interpret the provisions of the Plan; (2) establish and revise the method of accounting for the Plan; (3) establish rules and prescribe any forms required for administration of the Plan; (4) change the Plan; and (5) terminate the Plan.

The Plan Sponsor, by action of an authorized officer or committee, reserves the right to change the Plan. This includes, but is not limited to, changes to contributions, deductibles, copayments, benefits payable and any other terms or conditions of the Plan. The Plan Sponsor's decision to change the Plan may be due to changes in applicable laws, or for any other reason. The Plan may be changed to transfer the Plan's liabilities to another plan or split the Plan into two or more parts.

The Plan Sponsor shall have the power to delegate specific duties and responsibilities. Any delegation by the Plan Sponsor may allow further delegations by such individuals or entities to whom the delegation has been made. Any delegation may be rescinded by the Plan Sponsor at any time. Each person or entity to whom a duty or responsibility has been delegated shall be responsible for only those duties or responsibilities, and shall not be responsible for any act or failure to act of any other individual or entity.

HealthPartners Trademarks. HealthPartners names and logos and all related products and service names, design marks and slogans are the trademarks of HealthPartners or its related companies.

No Guarantee of Employment. The adoption and maintenance of the Plan shall not be deemed to be a contract of employment between the Plan Sponsor and any covered employee. Nothing contained herein shall give any covered employee the right to be retained in the employment of the Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge any covered employee, any time, nor shall it give the Plan Sponsor the right to require any covered employee to remain in its employment or to interfere with the covered employee's right to terminate his or her employment at any time.

I. INTRODUCTION TO THE SUMMARY OF BENEFITS

A. SUMMARY OF BENEFITS ("SB")

This SB is your description of the Employer's Dental Benefit Plan ("the Plan"). It describes the Plan's benefits and limitations. It describes the amounts of payments and limits for the coverage provided under this SB. Benefits are further described in section III.

This SB should be read completely. Many of its provisions are interrelated; reading just one or two provisions may give you incomplete information regarding your rights and responsibilities under the Plan. Many of the terms used in this SB have special meanings and are specifically defined in the SB. Your SB should be kept in a safe place for your future reference.

The Plan is maintained exclusively for covered employees and their covered dependents. Each covered person's rights under the Plan are legally enforceable.

B. ADMINISTRATIVE AGREEMENT

This SB, together with the Administrative Agreement between the Plan Sponsor and HPAI, as well as any amendments and any other documents referenced in the Administrative Agreement, constitute the entire agreement between HealthPartners and the Plan Sponsor. A version of the Administrative Agreement is available for inspection at the Employee Insurance Division of Minnesota Management & Budget or at HealthPartners' home office, at 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

C. IDENTIFICATION CARD

An identification card will be issued to you at the time of enrollment. You will be asked to present your identification card, or otherwise show that you are a covered person, whenever you receive services. You may not permit anyone else to use your card to obtain care.

D. ASSIGNMENT OF BENEFITS

You may not assign or in any way transfer your rights under this SB.

E. CONTRIBUTIONS

This SB is conditioned on our regular receipt of covered persons' contributions toward the coverage provided by this SB. The contributions are made through the Plan Sponsor, unless HPAI has agreed to another payment method. Contributions are based upon the plan type and the number and status of any dependents enrolled with the covered employee.

F. AMENDMENTS TO THIS SB

Amendments which are included with this SB or sent to you at a later date are incorporated and fully made a part of this SB.

G. CONFLICT WITH EXISTING LAW

In the event that any provision of this SB is in conflict with applicable law, that provision only is hereby amended to conform to the minimum requirements of the law.

H. HOW TO USE THE PLAN

1. BENEFITS

This SB describes your covered services and how to obtain them. The Plan provides both Network Dental Benefits (HealthPartners Benefits) and Non-Network Dental Benefits (Non-Network Benefits), from which you may choose to receive covered services each time you need dental care. Coverage may vary according to your provider selection. The provisions below contain certain information you need to know in order to obtain covered services.

Network Providers. These are any of the participating licensed dentists or other dental care providers or facilities who have entered into an agreement with HealthPartners to provide dental care services to covered persons. Enrolling in the Plan does not guarantee the availability of a particular provider on the list of network providers; provider availability depends on many factors, including but not limited to scheduling. When a provider is no longer part of the network, you must choose among remaining network providers to receive network benefits.

Non-Network Providers. These are licensed dentists or other dental care providers, or facilities not participating as network providers. Services from Non-Network Providers will be covered at the Non-Network benefit level. There are limited exceptions as described in this SB.

2. ABOUT THE NETWORK

To obtain HealthPartners Benefits for covered services, you must receive services from network providers. Under limited circumstances, HealthPartners may authorize, at its discretion, the care delivered by non-network providers to be covered as HealthPartners Benefits. You must verify that your provider participates with the network each time you receive services.

Network. This is the network of participating network providers.

Network Dental Clinics. These are participating clinics providing dental services.

HealthPartners Service Area. This is the geographical area in which HealthPartners provides services to covered persons. Contact Member Services for information regarding the service area.

Second Opinions for Network Services. If you question a decision by a network dentist about dental care, the Plan covers a second opinion from a network dentist.

Referrals and Authorizations for HealthPartners Services. There is no referral requirement for services delivered by providers within your network. Your dentist will coordinate the authorization process for any services which must first be authorized. Under limited circumstances, HealthPartners may authorize, at its discretion, the care delivered by non-network providers to be covered as HealthPartners Benefits. **Referral:** This is a professional communication unrelated to benefits, introducing a patient to another provider, and requesting their involvement in the patient's care.

The Plan Sponsor or his or her designee makes coverage determinations and makes final authorization for certain covered services. Coverage determinations are based on established dental policies, which are subject to periodic review and modification by the Claims Administrator's dental directors or their designees. Certain benefit limitations may be waived upon submission, by your dentist, of documentation of dental necessity.

Call Member Services at 952-883-7900 or 888-343-4404 (toll-free) outside the metro area for more information on authorization requirements.

I. ACCESS TO RECORDS AND CONFIDENTIALITY

The Plan Sponsor complies with applicable state and federal laws governing the confidentiality and use of protected health information and dental records. As part of this Summary of Benefits, the Plan Sponsor is authorized to have access to and use protected health information held by any health care provider who delivers health care services to you under this Summary of Benefits. The Plan Sponsor is also allowed to use your protected health information, when necessary, for certain health care operations including, but not limited to: claims processing, quality of care assessment and improvement; accreditation, credentialing, case management; care coordination and utilization management, disease management, underwriting, premium rating, claims experience reporting, the evaluation of potential or actual claims against the Plan Sponsor, auditing and legal services, and other access and use without further authorization if permitted or required by another law.

In the event that protected health information is disclosed to the Plan Sponsor, the Plan Sponsor may only use or disclose such information as permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations promulgated thereunder and as amended including certain plan administrative functions such as: claims review, quality assurance, auditing, monitoring and management of carve out plans. Information may only be disclosed to the Plan Sponsor upon receipt, by the Plan, of a certification from the Plan Sponsor to the amendment of the Plan documents and that your Plan Sponsor agrees to:

- Not use or further disclose information except as listed above or as required or permitted by law;
- Ensure that any agents or subcontractors agree to the same restrictions and conditions that apply to your Employer or Plan Sponsor and that such agents and subcontractors agree to implement reasonable and appropriate security measures to protect electronic protected health information;
- Not use or disclose any information for employment – related actions or decisions;
- Not use or disclose any information in connection with any other employee benefit plan of your Employer or Plan Sponsor;
- Report to the Plan any security incident it becomes aware of and any use or disclosure of the information that is inconsistent with the uses or disclosures described above;
- Make information available to fulfill your right to access your protected health information;
- Make the information available for amendment or to incorporate applicable amendments;
- Make the information available in order to provide an accounting of disclosures;
- Make its internal practices, books and records relating to the use and disclosure of information received from the Plan available to the Department of Human Services to determine compliance with HIPAA;
- Return or destroy all protected health information received from the Plan, if feasible, when use or disclosure is no longer required. If return or destruction is not possible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- Ensure only certain classes of employees designated by your Employer are permitted access to your protected health information for Plan administration functions;
- Implement an effective mechanism for handling noncompliance by the employees designated access to your protected health information;
- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic protected health information that is created, received, maintained or transmitted on behalf of the group health plan; and
- Ensure adequate separation between the Plan and your Plan Sponsor is supported by reasonable and appropriate security measures.

J. PREDETERMINATION OF BENEFITS

If a course of treatment is expected to involve charges for dental services in certain categories of care, such as Periodontics, Endodontics, Special Services, Prosthetic Services or Orthodontics, of $300 or more, it is recommended that a description of the procedures to be performed, an estimate of the dentist's charges and an appropriate x-ray pertaining to the treatment, be filed by the dentist with the Claims Administrator in writing, prior to the course of treatment.

A "course of treatment" means a planned program of one or more services or supplies, whether rendered by one or more dentists, for treatment of a dental condition, diagnosed by the attending dentist as a result of an oral examination. The course of treatment commences on the date a dentist first renders a service to correct, or treat, such diagnosed dental condition.

Call Member Services for more information on predetermination of benefits.

The Claims Administrator will notify the dentist of the predetermination, based on the course of treatment. In determining the amount the Plan pays, consideration is given to alternate procedures, services, supplies, or courses of treatment, which may be performed for such dental condition. The amount the Plan pays as authorized dental charges is the appropriate amount determined in accordance with the terms of this SB.

If a description of the procedures to be performed, and an estimate of the dentist's charges, are not submitted in advance, the Plan reserves the right to make a determination of benefits payable, taking into account alternate procedures, services, supplies or courses of treatment, based on accepted standards of dental practice.

Predetermination of payment for services to be performed is limited to services performed within 90 days from the date such course of treatment was approved. Additional services required after 90 days must be submitted in writing, as a new course of treatment, and approved on the same basis as the prior plan.

II. DEFINITIONS OF TERMS USED

Calendar Year. This is the twelve-month period beginning 12:01 A.M. Central Time on January 1 and ending 12:00 A.M. Central Time of the next following December 31.

CareLine℠ Service. This is a service which employs a staff of registered nurses who are available by phone to assist covered persons in assessing their need for dental care, and to coordinate after-hours care, as covered in this SB.

Charge. For covered services delivered by participating network providers, is the provider's negotiated charge for a given dental/surgical service, procedure or item, which network providers have agreed to accept as payment in full.

For covered services delivered by non-network providers, is the provider's charge for a given dental/surgical service, procedure or item, up to the Plan's maximum amount allowed for that service, procedure or item.

To be covered, a charge must be incurred on or after the covered person's effective date and on or before the termination date. For participating network provider charges, the amount of the copayment or coinsurance, or the amount applied to the deductible, is based on the agreed fee applicable to the network provider, or a reasonable estimate of the cost according to a fee schedule equivalent. For non-network provider charges, the amount considered as a copayment or coinsurance, or the amount applied to the deductible, is based on the lesser of the billed charge and the Plan's maximum amount allowed.

Clinically Accepted Dental Services. These are techniques or services, accepted for general use, based on risk/benefit implications (evidence based). Some clinically accepted techniques are approved only for limited use, under specific circumstances.

Consultations. These are diagnostic services provided by a dentist or dental specialist other than the practitioner who is providing treatment.

Copayment/Coinsurance. The specified dollar amount or percentage of charges incurred for covered services, which the Plan does not pay, but which a covered person must pay, each time a covered person receives certain dental services, procedures or items. The Plan's payment for those covered services or items begins after the copayment or coinsurance is satisfied. Covered services or items requiring a copayment or coinsurance are specified in Section III. For participating network provider charges, the amount considered as a copayment or coinsurance is based on the agreed fee applicable to the network provider, or a reasonable estimate of the cost according to a fee schedule equivalent. For non-network provider charges, the amount considered as a copayment or coinsurance is based on the lesser of the billed charge or the Plan's maximum amount allowed. A copayment or coinsurance is due at the time a service is rendered, or when billed by the provider.

Cosmetic Care. These are dental services to improve appearance, without treatment of a related illness or injury.

Covered Dependent. This is an eligible dependent enrolled in the Plan.

Covered Employee. This is an eligible employee as defined in Collective Bargaining Agreements, as determined by MMB, who is enrolled in the Plan.

Covered Person. This is the person covered for benefits and all of his or her eligible and enrolled dependents. When used in this SB, "you" or "your" has the same meaning as Covered Person.

Covered Service. This is a specific dental service or item, which is dentally necessary and covered under the Plan, as specifically described in this SB.

Customary Restorative Materials. These are amalgam (silver fillings), glass ionomer and intraorally cured acrylic resin and resin-based composite materials (white fillings).

Date of Service. This is generally the date the dental service is performed. For prosthetic, or other special restorative procedures, the date of service is the date impressions were made for final working models. For endodontic procedures, date of service is the date on which the root canal was first entered for the purpose of canal preparation.

Deductible. The specified dollar amount of charges incurred for covered services, which the Plan does not pay, but a covered person or a family has to pay first in a calendar year. The Plan's payment for those services or items begins after the deductible is satisfied. If you have a family deductible, each individual family member may only contribute up to the individual deductible amount toward the family deductible. An individual's copayments and coinsurance do not apply toward the family deductible. The amount of the charges that apply to the deductible are based on (1) the agreed fee applicable to the network provider, or a reasonable estimate of the cost according to a fee schedule equivalent; or (2) the lesser of the billed charge and the Plan's maximum amount allowed for the non-network provider. This SB indicates which covered services are not subject to the deductible.

Deductibles shown below are combined under your HealthPartners Benefits and Non-Network Benefits.

	HealthPartners Benefits	**Non-Network Benefits**
Individual Calendar Year Deductible	$50	$125
Family Calendar Year Deductible	$150	None.

Dentally Necessary. This is care which is limited to diagnostic examination, treatment, and the use of dental equipment and appliances and which is required to prevent deterioration of dental health, or to restore dental function. The covered person's general health condition must permit the necessary procedure(s). Decisions about dental necessity are made by the Claims Administrator's dental directors or their designees, subject to final coverage determination by the Plan Sponsor.

Dentist. This is a professionally degreed doctor of dental surgery or dental medicine who lawfully performs a dental service in strict accordance with governmental licensing privileges and limitations.

Elective Procedures. These are procedures which are available to patients but which are not dentally necessary.

Eligible Dependents. Minnesota Management & Budget (MMB) determines the eligibility of state employees and dependents subject to collective bargaining agreements and compensation plans and state and federal laws and regulations. Eligibility rules and requirements may change during a benefit year.
The Claims Administrator agrees to accept the eligibility decisions of MMB as binding.

MMB may require you to submit legal documentation acceptable to MMB to establish the eligibility of your dependents including the appropriate MMB certification form for evaluation of eligibility. If you do not provide documentation acceptable to MMB or knowingly provide false information as proof of eligibility, your dependents may be removed from the plan, and you may be required to reimburse the Plan for claims the Plan paid on behalf of the ineligible dependent during the period of ineligibility.

Currently, eligible dependents include the following:

1. **Spouse.** This is the spouse of a covered employee (if legally married under Minnesota Law). For the purposes of coverage, if that spouse works full-time for an organization employing more than 100 people and elects to receive either credits or cash (a) in place of health insurance or health coverage or (b) in addition to a health plan with a $750 or greater deductible through his/her employing organization, he/she is not eligible to be a covered dependent.

2. **Child.** This is a covered employee's child to age 26. "Dependent child" includes a covered employee's: (1) biological child, (2) child legally adopted by or placed for adoption with the covered employee, (3) stepchild, for a stepchild to be considered a dependent child, the covered employee must be legally married to the child's legal parent. (4) foster child who has been placed with the employee or the employee's spouse by an authorized placement agency or by a judgment, decree, or other court order the employee and/or the employee's spouse must have full and permanent legal and physical custody and the foster child must not be eligible for other public programs.

3. **Grandchild.** A dependent grandchild, to age 25, is an eligible employee's unmarried dependent grandchild who: (a) is financially dependent upon the employee for principal support and maintenance and has resided with the employee continuously from birth or, (b) resides with the covered employee and is dependent upon the employee for principal support and maintenance and the employee's unmarried child (the parent) is less than age 19. If a grandchild is legally adopted or placed in the legal custody of the grandparent, they are covered as a dependent child under 2. Child.

4. **Disabled Dependent.** A disabled dependent child is a covered employee's child or grandchild regardless of marital status, who was disabled prior to the limiting age or any other limiting term required for dependent coverage and who continues to be incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability and is chiefly dependent upon the covered employee for support and maintenance, provided proof of such incapacity and dependency is furnished to the Claims Administrator by the employee or enrollee within 30 days of the child's attainment of the limiting age or any other limiting term required for dependent coverage. The disabled dependent is eligible to continue coverage as long as s/he continues to be disabled and dependent, unless coverage terminates under the contract.

5. **Qualified Medical Child Support Order.** A child who is required to be covered by a Qualified Medical Child Support Order (QMSCO) is considered an eligible dependent.

6. **Other.** Any person who is required by federal or state law to be a covered dependent.

   Certain related adults and adult dependent children participating in SEGIP.

   When these two categories of related adults each are eligible to participate in SEGIP one may cover the other as a dependent:
   - When both spouses work for the state, or another organization participating in SEGIP, and are married to each other, one of the spouse may be covered as a dependent by the other spouse.
   - When the participating employee's adult child (age 18 until 26) works for the state, or another organization participating in SEGIP, the adult child may be covered as a dependent by the parent.

   In either situation, the employee who will be covered as a dependent must waive coverage by completing the Waiver of Medical Coverage – Enrolled on Another State Employee's Coverage within their initial enrollment period, during an Open Enrollment Period, or midyear upon a permitted Qualified Life Event. Enrollment and dependent verification must be completed within the appropriate time periods. Only one state employee can cover dependents in common.

   The dependent/employee may move to his/her own plan during the annual Open Enrollment or midyear upon a permitted Qualified Life Event. The dependent/employee will be required to enroll in his/her own plan if the spouse/employee or parent/employee ceases to participate in SEGIP or when the adult child/employee reaches age 26 and is no longer eligible as a dependent.

Emergency Dental Care. These are services for an acute dental condition that would lead a prudent layperson to reasonably expect that the absence of immediate care would result in serious impairment to the dentition or would place the person's oral health in serious jeopardy.

Endodontics. This is the treatment of diseases of the dental pulp. Endodontics includes root canal therapy, pulp capping procedures, apexification and periapical procedures associated with root canal treatment.

Employee. This is a person who is eligible as specified by the Employer.

Individual Calendar Year Maximum Benefit. The specified coverage limit paid for all charges combined and actually paid by the Plan for a covered person under that coverage. The Plan's payment ceases for that covered person when that limit is reached. The covered person has to pay for subsequent charges in that year. The charges incurred for Orthodontic Services do not apply to the Individual Calendar Year Maximum Benefit.

Maximums shown below are combined under your HealthPartners Benefits and Non-Network Benefits.

	HealthPartners Benefits	**Non-Network Benefits**
Calendar Year Maximum Benefit	$1,500	$1,500

Investigative: As determined by HealthPartners, a drug, device or dental treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. The following categories of reliable evidence will be considered, none of which shall be determinative by itself:

1. Whether there is final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the United States Food and Drug Administration (FDA); if the drug or device or dental treatment or procedure is the subject of ongoing Phase I, II or III clinical trials; or if the drug, device or dental treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and

2. Whether there are consensus opinions or recommendations in relevant scientific, medical and/or dental literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether a drug is included in the American Hospital Formulary Service as appropriate for its proposed use; and

3. Whether there are consensus opinions of national and local health care providers in the applicable specialty as determined by a sampling of providers, including whether there are protocols used by the treating facility or another facility studying the same drug, device, dental treatment or procedure.

Medicare. This is the federal government's health insurance program under Social Security (Title XVIII). Medicare provides health benefits to people who are age 65 or older, or who are permanently disabled. The program has two parts, Part A and Part B. Part A generally covers the costs of hospitals and extended care facilities. Part B generally covers the costs of professional medical services. Both Parts are subject to Medicare deductibles.

MMB. This is Minnesota Management and Budget, the State agency responsible for administering the State Employee Group Insurance Program.

Oral Surgery. This is routine surgery involving teeth or alveolar bone, including extraction and alveolectomy. Oral surgery may include other oral treatment and surgery, if a dentist considers it dentally necessary. Oral surgery does not include orthodontia, orthognathic surgery, placement of dental implants or surgical care that is necessary because of a medical condition.

Orthodontics. This is dental care for the prevention, or correction of malocclusion of teeth and dental or facial disharmonies using appliances and techniques that alter the position of teeth in the jaws, including:
1. Limited Orthodontics. This is treatment with a limited objective, not involving the entire dentition.
2. Interceptive Orthodontics. This is treatment that is performed to lessen the severity or future effects of a malformation. Treatment may occur in the primary or transitional dentition.
3. Comprehensive Orthodontics. This includes multiple phases of treatment provided at different stages of development.

Orthognathic Surgery. This is oral surgery to alter the position of the jaw bones.

Periodontics. This is non-surgical and surgical treatment of diseases of the gingiva (gums) and bone supporting the teeth.

Prosthetic Services. These are services to replace missing teeth; including the prescribing, repair, construction, replacement and fitting of fixed bridges and full or partial removable dentures.

SEGIP. This is the program known as the State Employee Group Insurance Program.

III. DESCRIPTION OF COVERED SERVICES

The Plan agrees to cover the dental services described below.

This dental plan allows you to choose, at any time, dentists within the HealthPartners Dental Network (HealthPartners Benefits), or dentists outside of the Network (Non-Network Benefits).

The amount that the Plan pays for covered services is listed below. The covered person is responsible for the specified dollar amount and/or percentage of charges that the Plan does not pay. To be covered under this section, dental services or items described below must be dentally necessary. Coverage for eligible services is subject to the exclusions, limitations and other conditions of this SB.
The date of service must be while you are covered under the Plan.

Deductibles, Limits and Maximums shown below are combined under your HealthPartners Benefits and Non-Network Benefits.

	HealthPartners Benefits	**Non-Network Benefits**
Individual Calendar Year Deductible	$50	$125
Family Calendar Year Deductible	$150	None.
Calendar Year Maximum Benefit	$1,500	$1,500

A. PREVENTIVE AND DIAGNOSTIC SERVICES.

The Plan covers, with certain limitations:

For this category, deductible does not apply.

	HealthPartners Benefits	**Non-Network Benefits**
Routine dental care examinations for new and existing patients	100% of the charges incurred, limited to twice each calendar year.	50% of the charges incurred, limited to twice each calendar year.
Dental cleaning (prophylaxis or periodontal maintenance cleaning	100% of the charges incurred, limited to twice each calendar year.	50% of the charges incurred, limited to twice each calendar year.
Professionally applied topical fluoride	100% of the charges incurred, limited to once each calendar year for covered persons under age 19.	50% of the charges incurred, limited to once each calendar year for covered persons under age 19.
Bitewing x-rays	100% of the charges incurred, limited to once each calendar year.	50% of the charges incurred, limited to once each calendar year.
Full mouth or panoramic x-rays	100% of the charges incurred, limited to once every three years.	50% of the charges incurred, limited to once every three years.

	HealthPartners Benefits	Non-Network Benefits
Other x-rays, except x-rays provided in connection with orthodontic diagnostic procedures and treatment	100% of the charges incurred, limited to once each calendar year.	50% of the charges incurred, limited to once each calendar year.
Space maintainers(fixed or removable appliances designed to prevent adjacent and opposing teeth from moving)	100% of the charges incurred, for lost primary teeth for covered persons under age 19.	50% of the charges incurred, for lost primary teeth for covered persons under age 19.
Evaluations that are not routine and periodic, including: problem-focused evaluations (either limited or detailed and extensive), periodontal evaluations, and evaluations for members under the age of 3 which include counseling with the primary caregiver	100% of the charges incurred.	50% of the charges incurred.
Screening or assessments of a patient	100% of the charges incurred, limited to twice each calendar year.	50% of the charges incurred, limited to twice each calendar year.
Oral hygiene instruction	100% of the charges incurred.	50% of the charges incurred.

Oral hygiene instruction is limited to once per lifetime as an independent procedure.

B. BASIC SERVICES.

The Plan covers, with certain limitations:

Basic I Services

	HealthPartners Benefits	Non-Network Benefits
Consultations	80% of the charges incurred.	50% of the charges incurred.
Emergency treatment for relief of pain	80% of the charges incurred.	50% of the charges incurred.
Pit and fissure sealant application and preventive resin restorations	80% of the charges incurred, limited to one application per tooth per three-year period, for permanent molars.	50% of the charges incurred, limited to one application per tooth per three-year period, for permanent molars.

	HealthPartners Benefits	Non-Network Benefits
Fillings - restorations using customary restorative materials and stainless steel crowns, when dentally necessary due to loss of tooth structure as a result of tooth decay or fracture		
regular restorative services other than posterior composites	80% of the charges incurred.	50% of the charges incurred.
posterior composites (white fillings on bicuspids and molars)	80% of the charge which is appropriate for an equivalent amalgam/silver filling restoration.	50% of the charge which is appropriate for an equivalent amalgam/silver filling restoration.
Oral surgery - for the restoration of dental function. Intravenous conscious sedation, when dentally necessary provided by the attending dentist in a dental office setting and required to perform a covered dental procedure– non-surgical extraction	80% of the charges incurred.	50% of the charges incurred.
Periodontics (Gum Disease) – non-surgical treatment	80% of the charges incurred, limited to once in two years.	50% of the charges incurred, limited to once in two years.
Endodontics (Root canal therapy)	80% of the charges incurred.	50% of the charges incurred.

Endodontics (root canal therapy) is limited to once per tooth per lifetime.

Full mouth debridement is limited to once per lifetime.

Basic II Services

	HealthPartners Benefits	Non-Network Benefits
Oral surgery - for the restoration of dental function. Intravenous conscious sedation, when dentally necessary provided by the attending dentist in a dental office setting and required to perform a covered dental procedure– other than non-surgical extraction	80% of the charges incurred.	50% of the charges incurred.
Periodontics (Gum Disease) – surgical treatment	80% of the charges incurred, limited to once in two years.	50% of the charges incurred, limited to once in two years.

C. SPECIAL SERVICES.

The Plan covers, with certain limitations:

	HealthPartners Benefits	**Non-Network Benefits**
Special restorative care – extraorally fabricated or cast restorations (crowns, onlays) when teeth cannot be restored with customary restorative material and when dentally necessary due to the loss of tooth structure as a result of tooth decay or fracture If a tooth can be restored with a customary restorative material, but an onlay, crown, jacket, indirect composite or porcelain/ceramic restoration is selected, benefits will be calculated using the charge appropriate to the equivalent customary restorative material.	80% of the charges incurred.	50% of the charges incurred.
Repair or recementing of crowns, inlays and onlays	80% of the charges incurred.	50% of the charges incurred.

Limitation on the replacement of an existing crown: Benefit for the replacement of a crown or onlay will be provided only after a five year period measured from the date on which the procedure was last provided, whether under this Plan or not.

D. PROSTHETIC SERVICES.

The Plan covers, with certain limitations:

1. initial installation of fixed bridgework to replace missing natural teeth;
2. surveyed crowns which are not restorative but which are dentally necessary to facilitate the placement of a removable partial denture;
3. initial installation of partial or full removable dentures to replace missing natural teeth and adjacent structures and adjustments during the six-month period following installation. If a satisfactory result can be achieved by a standard cast chrome or acrylic partial denture, but a more complicated design is selected, the charges appropriate to the least costly appliance are covered. For full dentures, if a satisfactory result can be achieved through the utilization of standard procedures and materials but a personalized appliance is selected, or one which involves specialized techniques, the charges appropriate to the least costly appliance are covered;
4. replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework. A given prosthetic appliance for the purpose of replacing an existing appliance will be provided when satisfactory evidence is presented that the new prosthetic appliance is required to replace one or more teeth extracted after the existing denture or bridgework was installed;
5. repair or recementing of bridgework or dentures, or relining or rebasing of dentures more than six months after installation of an initial or replacement denture;
6. interim prosthetics for anterior teeth.

	HealthPartners Benefits	Non-Network Benefits
Bridges	50% of the charges incurred.	50% of the charges incurred.
Dentures	50% of the charges incurred.	50% of the charges incurred.
Partial Dentures	50% of the charges incurred.	50% of the charges incurred.

Limitation on the replacement of an existing prosthetic appliance: Benefit for replacement of a prosthetic appliance will be provided only (a) if the existing appliance cannot be made serviceable, and (b) after a 5 year period measured from the date on which it was installed, whether under this Plan or not.

E. DENTAL IMPLANT SERVICES.

The Plan covers:

1. the surgical placement of an implant body to replace missing natural teeth;
2. removal or replacement of an implant body that is not serviceable and cannot be repaired after a period of at least five years from the date that the implant body was initially placed;
3. initial installation of implant-supported prosthesis (crowns, bridgework and dentures) to replace missing teeth;
4. replacement of an existing implant-supported prosthesis by a new implant-supported prosthesis, or the addition of teeth to an existing implant-supported prosthesis. An existing implant-supported prosthesis will be replaced when satisfactory evidence is presented that (a) the new implant-supported prosthesis is required to replace one or more teeth extracted after the existing implant-supported prosthesis was installed;
5. repair of implant-supported prosthesis; and
6. bone grafting.

HealthPartners Benefits	Non-Network Benefits
50% of the charges incurred, subject to the dental implant services calendar year maximum shown below.	50% of the charges incurred, subject to the dental implant services calendar year maximum shown below.

Limitation on the replacement of an existing implant-supported prosthesis: Benefit for replacement of an existing implant-supported prosthesis that cannot be made serviceable will be provided only after a 5 year period measured from the date that the implant-supported prosthesis was initially placed, whether under this Plan or not

Dental Implant Services Calendar Year Maximum

HealthPartners Benefits	Non-Network Benefits
$600	$600

The dental implant services calendar year maximum under the HealthPartners Benefits and Non-Network Benefits is combined. Any benefits that apply toward the dental implant services calendar year maximum also apply toward the overall Calendar Year Maximum shown above.

F. EMERGENCY DENTAL CARE SERVICES.

The Plan covers emergency dental care to the same extent as eligible dental services specified above.

	HealthPartners Benefits	**Non-Network Benefits**
	Coverage level is the same as corresponding HealthPartners Benefits, depending on the type of service provided, such as fillings.	Coverage level is the same as corresponding Non-Network Benefits, depending on the type of service provided, such as fillings.

G. ORTHODONTIC SERVICES.

The Plan covers, with certain limitations: treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies to the age limit and orthodontic maximum shown below. Each limited, interceptive or comprehensive orthodontic treatment includes:

1. Treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies, to the age limit and orthodontic maximum shown below;
2. Surgical access of unerupted teeth and placement of a device to aid eruption;
3. Initial post-treatment retainers.

For this category, deductible does not apply

	HealthPartners Benefits	**Non-Network Benefits**
For dependent children under age 19	50% of the charges incurred.	50% of the charges incurred.
Lifetime Maximum	$2,400	$2,400

Benefits applied to any previous Contract Year Maximum Benefit for orthodontia will be applied toward the Orthodontic Services Lifetime Maximum.

The Plan pays up to the orthodontic maximum, less the total amount of any benefit received for orthodontic treatment under any prior dental coverage provided by the Plan Sponsor. It is the covered persons's responsibility to provide documentation of benefits received under prior coverage. Benefits will be paid over the course of orthodontic treatment.

IV. SERVICES NOT COVERED

In addition to any other benefit exclusions, limitations or terms specified in this SB, the Plan will not cover charges incurred for any of the following services, except as specifically described in this SB:

1. Treatment, procedures or services which are not dentally necessary and/or which are primarily educational in nature or for the vocation, comfort, convenience, appearance or recreation of the covered person.
2. The treatment of conditions which foreseeably result from excluded services.
3. Dental services or supplies which are performed primarily for cosmetic purposes or for the purpose of improving the appearance of your teeth. This includes tooth whitening, tooth bonding and veneers that cover the teeth.
4. Hospitalization or other facility charges.
5. Local anesthesia or use of electronic analgesia billed as a separate procedure is not covered. Nitrous oxide is not covered unless dentally necessary and required to perform a covered dental procedure. Intravenous conscious sedation is not covered except as indicated in section III. Description of Covered Services in this SB.
6. Orthodontic services, except as provided in this SB.
7. Orthognathic surgery (surgery to reposition the jaws).

8. Services which are elective, investigative, experimental or not otherwise clinically accepted.
9. Procedures, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, or erosion or realigning teeth, except as covered orthodontic services provided in this SB. Mandibular orthopedic appliances and bite planes are also not covered.
10. Services for the following items:
    (a) replacement of any missing, lost or stolen dental or implant-supported prosthesis.
    (b) replacement or repair of orthodontic appliances.
    (c) replacement of orthodontic appliances due to non-compliance.
11. Services related to a prosthetic or special restorative appliance which was installed or delivered more than 60 days after termination of coverage.
12. Diagnostic testing that is performed and billed as a separate procedure such as collection of microorganisms for culture, viral cultures, genetic testing for susceptibility or oral disease and caries susceptibility tests. This includes all oral pathology and laboratory testing charges.
13. Dental services, supplies and devices not expressly covered as a benefit under this SB.
14. Prescription drugs and medications prescribed by a dentist, including gingival irrigation.
15. Services provided to the covered person which the covered person is not required to pay.
16. The portion of a billed charge for an otherwise covered service by a non-network provider, which is in excess of the Plan's maximum amount allowed. Also not covered are charges or a portion of a charge which is either a duplicate charge for a service or charges for a duplicate service.
17. Services for injury or illness either (a) arising out of an injury in the course of employment and subject to workers' compensation or similar law; or (b) for which benefits are payable without regard to fault, under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance; or (c) for which benefits are payable under another policy of accident and health insurance, Medicare or any other governmental program.
18. Except where expressly addressed in the Description of Covered Services, when multiple, acceptable treatment options exist related to a specific dental problem, the Plan will provide benefits based upon the least costly alternative treatment. This includes inlay restorations paid as corresponding amalgam restorations.
19. Services covered under the patient's medical plan, except to the extent not covered under the patient's medical plan.
20. Additional charges for office visits that occur after regularly scheduled hours, office visits for observation, missed appointments or appointments cancelled on short notice.
21. Onlays, veneers or partial crowns fabricated from extraorally cured composite resin or porcelain.
22. Periodontal splinting.
23. Athletic mouthguards.
24. Charges for infection control, sterilization and waste disposal.
25. Charges for sales tax.
26. For HealthPartners Benefits, treatment, procedures or services which are not provided by a network dentist or other authorized provider or are not authorized by HealthPartners.
27. For Non-network services, dental services related to the replacement of any teeth, missing prior to the covered person's effective date under the Plan.
28. Procedures, appliances or restorations for the prevention of bruxism (grinding of teeth) or clenching.
29. Treatment, procedures, or services or drugs which are provided when you are not covered under this Plan.
30. Cone beam CT capture and interpretation.
31. Maxillofacial MRI, maxillofacial ultrasound and sialoendoscopy capture and interpretation.
32. Harvest of bone for use in autogenous grafting procedure.
33. The controlled release of therapeutic agents or biologic materials used to aid in soft tissue and osseous tissue regeneration.
34. Charges for guided tissue regeneration.
35. Deep sedation/general anesthesia for non-surgical or surgical dental care.
36. Maxillofacial prosthetics.
37. Charges for case presentations for treatment planning or behavioral management.
38. Charges for enamel microabrasion, odontoplasty and pulpal regeneration.
39. Charges for surgical procedures for isolation of a tooth with a rubber dam.
40. Charges for fixed or removable appliances to control harmful habits such as tongue thrusting or thumb sucking.
41. Charges for cleaning and inspection of a removable appliance.

42. Post processing of image or image sets.
43. Caries risk assessment and documentation.
44. Charges for unspecified procedures.
45. Charges for the placement of a restorative foundation for an indirect restoration.
46. Charges for periradicular services and bone grafts or other material used in conjunction with periradicular surgery.
47. Non-dental administrative fees and charges including, but not limited to dental record preparation and interest charges.
48. Charges for provisional crowns, temporary crowns or crown lengthening.
49. Charges for direct or indirect pulp caps or pulpal debridement.
50. Charges for incomplete root canal therapy.

V. DISPUTES AND COMPLAINTS

A. DETERMINATION OF COVERAGE

Eligible services are covered only when dentally necessary for the proper treatment of a covered person. Frequency limits, deductibles, copayments or coinsurance, or other maximums or limits for certain covered services may not apply for certain medical conditions if you meet specific coverage criteria set by the Claims Administrator's dental directors. HealthPartners dental director, or his or her designee, makes coverage determinations of dental necessity, restrictions on access and appropriateness of treatment; however the Plan Sponsor will make final authorization for covered services.

B. COMPLAINTS

In General: The Plan has a complaint procedure to resolve claims and disputes. Complaints should be made in writing or orally. They may concern the provision of care, administrative actions or claims related to the Plan. The Plan's complaint system is limited to covered persons, applicants and former covered persons seeking to resolve a dispute which arose during their coverage or application for coverage.

Complaints must be sent or directed to:
HealthPartners
Member Services Department
8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: 952-883-7900 Outside the metro area: 888-343-4404 (toll-free)
TTY Telephone Number: 952-883-5127 Outside the metro area: 888-850-4762 (toll-free)

VI. CONDITIONS

A. It is the policy of the Claims Administrator to treat all persons alike, without distinction based on race, color, religion, national origin, handicap, sex or age. If you have questions about this policy, contact Member Services at 952-883-7900 or at 888-343-4404 (toll-free). Hearing impaired covered persons with a TTY phone may contact Member Services at 952-883-5127 or at 888-850-4762 (toll-free). If you have an impairment that requires alternative communication formats such as Braille, large print or audio cassettes, please request these materials from Member Services at the phone numbers listed above. If this SB is provided in one of these alternative communication formats, this written version governs all coverage decisions.

B. EVENTS BEYOND OUR CONTROL

The Claims Administrator is not liable for any delay or failure to provide services or for any consequences thereof due to events beyond their control. Such events may include, but are not limited to: (1) non-Claims Administrator labor disputes; (2) an epidemic; (3) a public emergency; (4) a natural disaster; (5) the partial or total destruction of HealthPartners or referral provider facilities; or (6) the unavailability of HealthPartners or referral provider personnel.

C. COORDINATION OF BENEFITS

You agree, as a covered person, to permit the Claims Administrator to coordinate the Plan's obligations under this SB with payments under any other health or dental benefit plans as specified below, which cover you or your dependents. You also agree to provide any information or submit any claims to other health or dental benefit plans necessary for this purpose. If you fail to provide this information, your claim may be delayed or denied. You agree to authorize the Claims Administrator's billing to other health or dental plans, for purposes of coordination of benefits.

1. Applicability.

a. This coordination of benefits (COB) provision applies to this SB when a covered person has health or dental care coverage under more than one plan. "Plan" and "This Plan" are defined below.

b. If this coordination of benefits provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

(1) shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but

(2) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in paragraph 4. below.

2. Definitions.

a. **"Plan"** is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

b. **"This Plan"** is the part of this SB that provides benefits for dental care expenses.

c. **"Primary Plan/Secondary Plan"** The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more of the plans and may be a Secondary Plan as to a different plan or plans.

d. **"Allowable Expense"** is a necessary, reasonable and customary item of expense for health or dental care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

When a plan provides benefits in the form of services, the reasonable cash value of each service provided will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

e. **"Claim Determination Period"** is a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

3. Order of Benefit Determination Rules.

a. **General**. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of another plan, unless:

(1) the other plan has rules coordinating its benefits with those of This Plan; and

(2) both those rules and This Plan's rules, in subparagraph b. below, require that This Plan's benefits be determined before those of the other plan.

b. **Rules**. This Plan determines its order of benefits using the first of the following rules which applies:

(1) Nondependent/Dependent. The benefits of the plan which cover the person as a covered person or subscriber (that is, other than as a dependent) are determined before those of the plan which cover the person as a dependent.

(2) Dependent Child/Parents not Separated or Divorced. Except as stated in subparagraph b., (3.) below, when This Plan and another plan cover the same child as a dependent of different persons, called "parents":

(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; but

(b) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described in "(a.)" immediately above, but instead has a rule based on the gender of the parent, and if, 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) Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) first, the plan of the parent with custody of the child;

(b) then, the plan of the spouse of the parent with the custody of the child; and

(c) finally, the plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health or dental care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for health or dental care expenses of the child, the plans covering follow the order of benefit determination rules outlined in subparagraph b., 2.

(5) Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which cover that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(6) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered a covered person or subscriber longer are determined before those of the plan which covered that person for the shorter term.

4. Effect on the Benefits of This Plan.

a. **When This Section Applies**. This paragraph 4. applies when, in accordance with paragraph 3. "Order of Benefit Determination Rules", This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in b. immediately below.

b. **Reduction in This Plan's Benefits**. The benefits of This Plan will be reduced when the sum of:

(1) the benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

(2) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of The Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of The Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

5. Right to Receive and Release Needed Information. Certain facts are needed to apply these COB rules. The Claims Administrator has the right to decide which facts are needed. Consistent with applicable state and federal law, the Claims Administrator may get needed facts from or give them to any other organization or person, without your further approval or consent. Unless applicable federal or state law prevents disclosure of the information without the consent of the patient or the patient's representative each person claiming benefits under This Plan must give any facts the Claims Administrator needs to pay the claim.

6. Facility of Payment. A payment made under another plan may include an amount which should have been paid under This Plan. If it does, the Claims Administrator may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Claims Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

7. Right of Recovery. If the amount of the payments made by the Plan is more than should have been paid under this COB provision, the Claims Administrator may recover the excess from one or more of:

a. the persons it has paid or for whom it has paid;
b. insurance companies; or
c. other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

The benefits provided by This Plan do not apply to injury or disease covered by no-fault insurance, employers liability laws (including workers' compensation), and care available or required to be furnished by or through national or state governments or their agencies including care to which a covered person is legally entitled and for which facilities are reasonably available for military service-connected conditions or disabilities. The Plan will provide dentally necessary services upon request and only pay expenses incurred for dental treatment otherwise covered by This Plan if the no-fault insurer, employer, or national or state government or its agencies refuse to pay said expenses. You must cooperate with the Plan's program to bill allowable no-fault and workers' compensation claims to the appropriate insurer(s).

VII. EFFECTIVE DATE AND ELIGIBILITY

A. EFFECTIVE DATE

The initial effective date of coverage is the first 35th calendar day after the first day of employment, rehire or reinstatement. A covered employee must be actively at work on the initial effective date of coverage or coverage will be delayed until the first day of the pay period following the date the covered employee returns to active payroll status. Notwithstanding the foregoing, if the covered employee is not actively at work on the initial effective date of coverage due to health status, medical condition, or disability, or that of the covered employee's covered dependent, as such terms are defined in Section 9802(a) of the Internal Revenue Code and the regulations related to that Section, coverages shall not be delayed.

If an eligible employee and his or her dependents apply for coverage during an open enrollment period, coverage will become effective on the date specified by MMB.

A newborn child's coverage takes effect from the moment of birth. Adopted children are covered from the date of placement for the purposes of adoption, and disabled dependents are covered from the covered employee's effective date of coverage, even though they are hospitalized on the effective date of coverage.

For a former legislator, the effective date of coverage is the first day of the month following or coinciding with the date of application.

Coverage for a covered employee's enrolled dependents begins on the covered employee's effective date, so long as the covered employee has applied for dependent coverage, the family premium payment is being paid, and the Claims Administrator has accepted the dependent. Dependents may only be added in accordance with the criteria set out in this SB, the Administrative Agreement and by the State of Minnesota, Minnesota Management and Budget.

For the purposes of this entire section, a dependent's coverage may not take effect prior to a covered employee's coverage.

B. ELIGIBILITY

The Minnesota Management & Budget will determine who constitutes an Eligible Employee or Dependent for the purpose of participating in the State Employee Group Insurance Program (SEGIP). These decisions are binding on HealthPartners Dental. A summary of individuals currently eligible as Dependents is contained in Section II, Definitions of Terms Used, Eligible Dependents.

C. CONVERSION

There is no right of conversion for covered persons under this dental Plan.

D. OFF-CYCLE ENROLLMENT WITHOUT EVIDENCE OF GOOD HEALTH

A covered person and his or her covered dependents will be allowed to make an enrollment choice outside of the annual open enrollment period or initial period of eligibility without evidence of good health within 30 calendar days of the events specified below. Decisions as to whether these circumstances occur are at the sole discretion of Minnesota Management and Budget and are binding on the Claims Administrator.

1. Any carrier participating in the SEGIP s placed into rehabilitation or liquidation, or is otherwise unable to provide the services specified in the SB.

2. Any carrier participating in the SEGIP loses all or a portion of its primary care provider network (including hospitals) to the extent that services are not accessible or available within thirty miles of the work station, including withdrawal from an approved service area.

3. Any carrier participating in the SEGIP terminates or is terminated from participation in the Program.

4. MMB approves a request from a covered employee or agency due to a breakdown in the open enrollment process such as systems errors or errors in the transmission of information. .

5. A covered employee is transferred to a location where a carrier is not operating. In addition, a covered employee who receives notification of a work location change between the end of an open enrollment period and beginning of the next plan year, may change his/her dental plan within 30 days of the date of relocation under the same provisions accorded during the last open enrollment period.

6. A covered employee may add coverage for all eligible dependents after the following events:

   a. A covered employee marries;

   b. If a covered employee's dependent loses group coverage, the covered employee may add dependent coverage. Loss of coverage includes any involuntary changes in coverage which result in termination of a dependent's coverage, regardless of whether it is immediately replaced by other subsidized coverage. Loss of coverage does not include the following:
      (i) A change in carriers through the same employer where the coverage is continuous and uninterrupted;
      (ii) A change in a dependent's health plan benefit levels; and
      (iii) A voluntary termination by the dependent, including but not limited to termination or reduction of coverage due to the adoption of cafeteria-style plans.

      The covered employee must provide a written request to MMB requesting dependent coverage in order to be eligible under this provision. The written request must be accompanied by a statement from the group plan administrator documenting the loss of coverage.

   c. When a covered employee acquires his/her first dependent child.

7. A former legislator and his or her dependents may elect coverage at any time; however, a former legislator's eligible dependent may not be enrolled for coverage unless the former legislator is also enrolled for coverage.

8. Retirees may elect to designate another carrier in the 60 days immediately preceding the effective date of retirement.

9. As otherwise specified by MMB.

E. CHOOSING A CARRIER

Active employees and their dependents may select a carrier based upon either work location or where they live. All other employees must choose a carrier based on where they live.

VIII. CONTINUATION OF GROUP DENTAL COVERAGE

As required by the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), if your eligibility for group coverage under the Plan ends because of one of the qualifying events shown below, you may be eligible to continue group coverage as shown below.

A. CONTINUATION OF GROUP COVERAGE

1. Qualifying Events. Coverage under the Plan may be continued by a covered employee, covered dependent spouse and other covered dependents, enrolled at the time coverage would otherwise end, or a child born to or placed for adoption with the covered employee during the period of continuation coverage, as a result of one of the following qualifying events:

   a. Termination of employment (except for gross misconduct) of the covered employee, or reduction in hours resulting in a loss of group coverage.
   b. Death of the covered employee.
   c. Divorce or legal separation of the covered employee.
   d. Loss of eligibility as a covered dependent child.
   e. Initial enrollment of the covered employee for Medicare.
   f. For a retired covered employee, spouse and other dependents, the bankruptcy filing by a former employer, under Title XI, United States Code, on or after July 1, 1986.

2. **Duration of Continuation Coverage.** The maximum period coverage can be continued depends on the qualifying event. Continuation coverage may be terminated earlier as shown below. The maximum period of continuation coverage starts on the day of the qualifying event.

   a. **Maximum period**

      (1) **Termination and reduced hours.** The maximum period of continuation coverage is 18 months. If a second qualifying event, other than the Employer's bankruptcy, occurs during the 18 months, the maximum period of continuation coverage is 36 months.

      (2) **Disabled covered employee, covered dependent spouse or covered dependent child.** If the covered employee, covered dependent spouse or other covered dependent is disabled under Title II or XVI of the Social Security Act, at the time of the termination of employment, or reduced hours of the covered employee, or within the first 60 days of continuation of coverage, the 18-month maximum continuation period may be extended to 29 months. The disabled person must notify the Plan Sponsor within 60 days of the date of determination of disability, and within the initial 18-month continuation period. If a second qualifying event (other than bankruptcy) occurs during the extended 29-month period, the maximum period of continuation coverage is 36 months.

      (3) **Bankruptcy.** In the case of bankruptcy of a retired covered employee's former employer, the maximum period of continuation coverage is until the death of the retired covered employee. In the case of the surviving spouse or dependent children of the retired covered employee, the maximum period of continuation coverage is 36 months after the death of the retired covered employee.

      (4) **Divorce or legal separation.** The maximum period of coverage for a former spouse or dependents who lose coverage due to divorce or legal separation is 36 months.

      (5) **Death of covered employee.** The maximum period of coverage for a covered dependent surviving spouse and covered dependents who lose coverage due to the death of the covered employee is 36 months.

      (6) **Other qualifying events.** The maximum period of continuation coverage for all other qualifying events is 36 months.

   b. **Earlier Termination**

      Coverage terminates before the end of the maximum period if any of the following occurs.

      (1) **End of the Plan.** The Plan under which this coverage is offered to covered employees is terminated.

      (2) **Failure to pay premium.** The person receiving continuation coverage does not make the monthly payment within 30 days of the due date.

      (3) **Other group dental coverage.** The person receiving continuation coverage becomes covered under any other group dental type coverage, not containing an exclusion or limitation for any pre-existing condition of the person. If the other group dental coverage contains a pre-existing condition limitation, continuation coverage is extended until the pre-existing limitation is satisfied or coverage is otherwise terminated. A person will not be subject to earlier termination of continuation coverage on account of coverage under another group plan that existed prior to that person's first day of continuation coverage.

      (4) **Termination of extended coverage for disability.** In case a person receives extended (29-month) continuation coverage due to disability at the time of termination or reduced hours, the extended coverage terminates at the beginning of the month 30 days after a final determination that the person is no longer disabled.

      (5) **Termination provisions of this Summary of Benefits.** The person's coverage is subject to termination under section IX. of this Summary of Benefits.

3. Election of Continuation Coverage

a. You have 60 days to elect continuation of group coverage. The 60-day period begins on the date your group coverage would otherwise terminate due to a qualifying event or the date on which written notice of your right of continued group coverage is mailed, whichever is later.

b. If you wish to continue group coverage as shown above, you must apply in writing to your Employer (not the Plan). You must also pay your first monthly payment within 45 days of the date you elected to continue group coverage. Thereafter, your monthly payments are due and payable at the beginning of each month for which coverage is to be continued.

c. You or your covered dependents must notify the Plan Sponsor within 60 days, when divorce, legal separation, change in status resulting in a loss of eligibility as a dependent would end coverage or a second qualifying event occurs. The 60 day period begins on the date of the divorce, legal separation, change in dependent status or second qualifying event.

4. Procedures for Providing Notices Required under this "Continuation of Group Coverage" section.

a. You must comply with the time limits for providing notices required in paragraph 3.c. above.

b. Your notice must be in writing and contain at least the following information:
   (1) The names of the covered employee and covered dependents;
   (2) The qualifying event or disability; and
   (3) The date on which the qualifying event (if any) occurred.

c. Your notice must be sent to:

   State of Minnesota
   Minnesota Management and Budget
   Employee Insurance Division
   400 Centennial Office Building
   658 Cedar Street,
   St. Paul, MN 55155

The plan will comply with applicable federal law for a covered employee that is called to active military duty in the uniformed services.

B. RETIREMENT

A covered employee who is retiring from state service or any group that is eligible to participate in the SEGIP, and who is eligible to maintain participation in the SEGIP as determined by MMB, may, consistent with state law, indefinitely maintain their dental coverage with the SEGIP by filling out the proper forms with their agency within thirty days of the effective date of their retirement.

If a retiring covered employee fails to make a proper election within the thirty-day time period, the retiring covered employee may continue coverage for up to eighteen months in accordance with state and federal law. See Section VIII. A. above for information on your continuation rights.

In any event, failure to pay the premium will result in termination of coverage. Once coverage has been terminated for any reason, voluntary or involuntary, the retiree, early retiree and/or their dependents may not rejoin the SEGIP.

IX. TERMINATION

Coverage of the covered employee and his or her covered dependents will terminate on the earliest of the following dates, except that coverage may be continued in some instances as specified above in Section VIII. of this SB.

1. For all covered persons, the date that either the Claims Administrator or MMB terminates the Plan.

2. For a covered employee, the end of the month in which the covered employee retires, unless the covered employee and his or her covered dependents elect to maintain coverage under this SB, or a separate Medicare contract.

3. For a covered employee and his or her covered dependents, the end of the month in which the covered employee's eligibility under this SB ends.

4. For a covered employee and his or her covered dependents, the end of the month in which a written request by the covered employee to cancel coverage is made. Approval to terminate coverage will only be granted if the request is consistent with a life event. Life events include, but are not limited to:
   a. loss of covered dependent status of a sole dependent;
   b. death of a sole covered dependent;
   c. divorce;
   d. change in employment condition of a covered employee or covered spouse;
   e. a significant change of spousal insurance coverage (cost of coverage is not a significant change); and
   f. during an open enrollment.

5. Consistent with a covered employee's ability to choose a dental plan on the basis of where he or she lives or works, for a covered employee, the date thirty days after notice by the Claims Administrator, when the covered employee no longer resides in the service area. For the purposes of this section, a student's address is considered to be the same as the covered employee's address when attending an accredited school on a full-time basis, even though the student may be located outside the service area.

6. For a covered dependent child, the end of the month in which the child is no longer eligible as a covered dependent, unless otherwise specified by MMB.

7. For a covered dependent, the effective date of coverage, if the covered employee or his or her dependents knowingly make fraudulent misstatements regarding the eligibility of the dependent for coverage.

8. For a covered employee that is directly billed by MMB, the end of the month during which the last full premium payment was paid, when the covered employee fails to make the payment within 30 days of the date the payment is billed or is due, whichever is later.

X. CLAIMS PROVISIONS

A. PROCEDURES FOR REIMBURSEMENT OF HEALTHPARTNERS SERVICES

When you present your identification card at the time of requesting benefits from HealthPartners network providers, paperwork and submission of claims relating to services will be handled for you by your provider. You may be asked by your provider to sign a form allowing your provider to submit the claim on your behalf. If you receive an invoice or bill from your provider for services other than coinsurance, copayments or deductible amounts, simply return the bill or invoice to your provider, noting your enrollment in the Plan. Your provider will then submit the claim under the Plan. Your claim will be processed for payment according to the Employer's coverage guidelines.

B. PROCEDURES FOR REIMBURSEMENT OF NON-NETWORK SERVICES

1. **Claim Forms.** If claim forms are needed, please contact the Claims Administrator at 952-883-7900 or at 888-343-4404 (toll-free). For hearing-impaired individuals, with a TTY phone call 952-883-5127 or 888-850-4762 (toll-free). You must submit claims to the Claims Administrator for non-network services on the claim form provided. Claim forms must include written proof which documents the date and type of service, provider name and charges, for which a claim is made.

2. **Proof of Loss.** Claims for non-network services must be submitted to the Claims Administrator at the address shown below. You must submit an itemized bill which documents the date and type of service, provider name and charges, for the services incurred. Claims for non-network services must be submitted within 90 days of the date services were first received for the injury or illness upon which the claim is based. Failure to file a claim within this period of time shall not invalidate nor reduce any claim if it was not reasonably possible to file the claim within that time. However, such claim must be filed as soon as reasonably possible and in no event, except in the absence of your legal capacity, later than one year from the date services were first received for the injury or illness upon which the claim is based. If the Plan is discontinued, the deadline for claim submission is 180 days. The Claims Administrator may request that additional information be submitted, as needed, to make a claim determination.

   Send itemized bills to:
   Claims Department
   HealthPartners, Inc.
   P.O. Box 1172
   Minneapolis, MN 55440-1172

3. **Time of Payment of Claims.** Benefits will be paid under the Plan within a reasonable time period.

4. **Payment of Claims.** Subject to any written direction of the covered employee in the application or otherwise, all or any portion of any benefits provided by this section on account of dental services may, at the Claims Administrator's option, unless the covered employee requests otherwise in writing (not later than the time of filing proofs of such loss), be paid directly to the dentist or provider providing such services, but it is not required that the services be provided by a particular dentist or provider.

   All payments for claims will be made directly to the provider of dental services, rather than to the covered person, for claims incurred by a child, who is covered as a dependent of a covered person who has legal responsibility for the covered dependent's dental care pursuant to a court order, provided the Claims Administrator is informed of such order. This payment will discharge the Claims Administrator from all further liability to the extent of the payment made.

5. **Information**. When you seek coverage for goods or services under this Plan, you grant the Plan Sponsor the right to collect and review any claims, eligibility, coordination of benefits, or medical or dental information necessary to make a proper determination of coverage under this Plan. In the event you fail to cooperate with or execute any documents necessary for review of coverage requests, the Plan Sponsor reserves the right to refuse to grant coverage without receipt of necessary information.

6. **Clerical Error.** If a clerical error or other mistake occurs, that error does not deprive you of coverage for which you are otherwise eligible nor does it give you coverage under the Plan for which you are not eligible. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverage. Determination of your coverage will be made at the time the claim is reviewed. It is your responsibility to confirm the accuracy of statements made by the Plan Sponsor or the Claims Administrator, in accordance with the terms of this SB and other Plan documents.

C. TIME OF NOTIFICATION TO CLAIMANT OF CLAIMS

An initial determination of a claim for benefits must be made by HealthPartners within 30 days. This time period may be extended for an additional 15 days, provided that the Claims Administrator determines that such an extension is necessary due to matters beyond the control of the Plan. If such extension is necessary, you will be notified prior to the expiration of the initial 30-day period.

You will receive written notification of any initial adverse claim determination as provided by applicable law.

D. CLAIM DENIALS AND CLAIM APPEALS PROCESS

If your claim for benefits under the Plan is wholly or partially denied, you are entitled to appeal that decision. Your Plan provides for two levels of appeal to the Named Fiduciary of your Plan or its delegate. You must exhaust both levels of appeal prior to bringing a civil action.

1. **First Level Appeal.** You or your authorized representative must file your appeal within 180 days of the adverse decision. Send your written request for review, including comments, documents, records and other information relating to the claim, the reasons you believe you are entitled to benefits, and any supporting documents to:

   Member Services Department
   HealthPartners, Inc.
   8170 33rd Avenue South, P.O. Box 1309
   Minneapolis, MN 55440-1309

   Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

   The Claims Administrator will review your appeal and will notify you of its decision within 30 days.

   The time period may be extended if you agree.

   All notifications described above will comply with applicable law.

2. **Final Level of Appeal to the Plan Sponsor.** If after the first level of appeal, your request was denied, you or your authorized representative may, within 180 days of the denial, submit a written appeal for review, including any relevant documents, to the Plan Sponsor and submit issues, comments and additional information as appropriate to:

   State of Minnesota
   Minnesota Management and Budget
   Employee Insurance Division
   400 Centennial Office Building
   658 Cedar Street,
   St. Paul, MN 55155

   The Plan Sponsor will review your appeal and will notify you of its decision within 30 days.

   The time period may be extended if you agree.

   All notifications described above will comply with applicable law.