HealthPartners®

Summary of Benefits

State Dental Plan - HealthPartners

TABLE OF CONTENTS

Section **Page**

State Dental Plan - HealthPartners
Summary of Benefits

Specific Information About the Plan

Summary of Benefits Effective Date: The later of January 1, 2020 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 State Dental Plan - HealthPartners which provides employee and dependent dental benefits.
Address of the Plan:	State of Minnesota Minnesota Management and Budget Employee Insurance 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 Minnesota Minnesota Management and Budget Employee Insurance
Agent for Service of Legal Process:	Lorna Smith, Director Minnesota Management and Budget Employee Insurance 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
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). All references to “HealthPartners” throughout this SB mean HPAI.

MMB ("Plan Sponsor"). MMB has established a Dental Benefit Plan ("the Plan" and /or “this 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: interpret the provisions of the Plan; establish and revise the method of accounting for the Plan; establish rules and prescribe any forms required for administration of the Plan; change the Plan; and 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 their 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 Section of Minnesota Management and 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, in any way, assign or transfer your rights or benefits under this SB. In addition, you may not, in any way, assign or transfer your right to pursue any causes of action arising under the Plan including, but not limited to, causes of action for denial of benefits under the Plan.

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 conflicts 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 Benefits and 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 Network 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 Network 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.

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 Network 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 Network 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 their 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. MEDICAL DATA PRIVACY

Effective date: September 23, 2013
Reissue date: October 23, 2018

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

A. Introduction

The State of Minnesota and other participating employers sponsor a Plan and are required by federal law to provide You this Notice of the Plan's privacy practices and related legal duties and of Your rights in connection with the use and disclosure of Your protected health information (PHI). Carefully review this Notice to understand your individual rights and the ways that the Plan protects your privacy.

PHI is defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its regulations (the "Privacy Rule"). PHI generally means individually identifiable health information that is created or received by a covered entity, including the Plan, in any form or media, including electronic, paper and oral. Individually identifiable health information includes demographic data, that relates to an individual's past, present or future physical or mental health or condition, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. For purposes of the Plan and this Notice, PHI includes information related to the medical claims that are submitted to the Plan about You, and information about the payment of those claims.

While this Notice is in effect, the Plan must follow the privacy practice described. The Plan reserves the right to change its privacy practices and the terms of this Notice at any time, provided that applicable law permits such changes. The Plan also reserves the right to make such changes effective for all PHI that the Plan maintains, including information created or received before the changes were made.

This Notice applies to all PHI the Plan maintains. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of Your medical information created in the doctor's office or clinic.

You may have additional rights under state law. State laws that provide greater privacy protection or broader privacy rights will continue to apply.

B. Health Plans covered by this Notice

This Notice describes the privacy practices of the group health plans listed here and together these plans are collectively referred to as the "Plan" for purposes of this Notice. Each of these plans is independent of one another. This Notice will apply to the extent that You participate in each separate plan. Minnesota Management & Budget / SEGIP contracts with internal and external entities to perform the work of each of these plans. In accordance with HIPAA, they may share PHI for the treatment, payment, and health care operations. Each entity is required to agree to additional terms and conditions to protect Your PHI.

Name of Plan	Plan Administrator	Claim Administrator
The Minnesota Advantage Health Plan	SEGIP	BlueCross BlueShield of Minnesota, BlueCross BlueShield of Minnesota PPO HealthPartners, HealthPartners PPO PreferredOne pharmacy benefit claims through CVS Caremark
The Advantage High Deductible Health Plan	SEGIP	BlueCross BlueShield of Minnesota, BlueCross BlueShield of Minnesota PPO HealthPartners, HealthPartners PPO PreferredOne pharmacy benefit claims through CVS Caremark
State Dental Plan - HealthPartners	SEGIP	HealthPartners
State Dental Plan – Delta Dental	SEGIP	Delta Dental
Flexible Benefits Accounts	SEGIP	121 Benefits LLC
Wellness Program	SEGIP	Virgin Pulse

C. The Plan's Rights and Obligations

1. The Plan is required by law to maintain the privacy of PHI.
2. The Plan is required by law to provide individuals with notice of the Plan's legal duties and privacy practices with respect to PHI.
3. The Plan is required to notify affected individuals of a breach of unsecured PHI.
4. The Plan is required to abide by the terms of the privacy practice described in this Notice. These privacy practices will remain in effect until the Plan replaces or modifies them.
5. The Plan reserves the right to change its privacy practices and the terms of this Notice at any time, provided that the change is permitted by law. The Plan reserves the right to have such a change affect all PHI it maintains, including PHI it received or created before the change. When the Plan makes a material change in its privacy practices, it will revise this Notice and post it at https://mn.gov/mmb/segip/ by the effective date of the material change and the Plan will provide the revised Notice, or information about the material change and how to obtain the revised Notice, in the next annual mailing to participants.

D. Uses and Disclosures of Your Protected Health Information

To protect the privacy of Your PHI, the Plan not only guards the physical security of Your PHI, but also limits the way Your PHI is used or disclosed to others. The Plan may use or disclose Your PHI in certain permissible ways, including the uses and disclosures described below. To the extent required by HIPAA, only the minimum amount of Your PHI necessary to perform these tasks will be used or disclosed. The following categories describe the different ways that the Plan uses and discloses your PHI. Not every use or disclosure within category is listed, but all uses and disclosures fall into one of the following categories.

1. **Your authorization**. Except as outlined below, the Plan will not use or disclose Your PHI unless You have signed a form authorizing the use or disclosure. You may give the Plan written authorization to use your PHI or to disclose it to anyone for any purpose. You have the right to revoke that authorization in writing and the Plan will stop using or disclosing Your PHI in accordance with that authorization except to the extent that the Plan has taken action in reliance upon the authorization. In addition, the Plan is required to obtain Your authorization under the following circumstances:

    a. Psychotherapy Notes. Most uses and disclosures of psychotherapy notes will require Your authorization.

    b. Marketing. Uses and disclosures of PHI which result in the Plan receiving financial payment from a third party whose product or services is being marketed will require Your authorization.

    c. Sale of PHI. Disclosures that constitute a sale of PHI will require Your authorization.

2. **Payment.** The Plan may use and disclose PHI about You for all activities that are included within the definition of "payment" under the Privacy Rule, such as determining Your eligibility for Plan benefits, the eligibility of Your dependents, facilitating payment for treatment and health care services You receive, determining benefit responsibility under The Plan, coordinating benefits with other Plans, or determining medical necessity. The Plan will also provide Your PHI to the extent necessary to provide required coverage for Your former spouse. The definition of "payment" includes many more items, so please refer to the Privacy Rule for a complete list.

3. **Health care operations**. The Plan may use and disclose PHI about You for health care operations. These uses and disclosures are necessary to operate the Plan. This may include developing quality improvement programs, conducting pilot projects, developing new programs, as well as cost management purposes. The definition of "health care operation" includes many more items, so please refer to the Privacy Rule for a complete list.

    The Plan will not sell your PHI. The Plan will not set Your premium or conduct underwriting for Your coverage using Your PHI. The Plan will not use Your genetic information for underwriting purposes. Plan members are required to verify the eligibility of their dependents.

4. **Treatment**. The Plan does not provide treatment. The Plan may use or disclose PHI for treatment purposes. This includes helping providers coordinate your healthcare. For example, a doctor may contact The Plan to ensure You have coverage or, in an emergency situation, to learn who are Your other providers or to contact Your family members if You are unable to provide this information.

5. **Disclosures to the Plan Sponsor (Your Employer)**. The State of Minnesota, or your participating employer, is the Plan Sponsor. The Plan may disclose Your PHI to them to the extent necessary to administer the Plan. These disclosures may be made only to designated personnel at the administrative units of the Employer, usually the benefits department or Your Human Resources department, and will be limited to the disclosures necessary for Plan administration functions. Generally, this will include enrollment and billing information. These individuals will protect the privacy of Your PHI and will ensure that it is only used as described in this Notice and as permitted by law. Your PHI will not be used by the Employer for any employment-related actions or decisions or in connection with any other benefit plan offered by the Employer.

6. **Sponsored health plan programs**. The Plan may use or disclose Your PHI to a HIPAA-covered health care provider, health plan, or health care clearinghouse, in connection with their treatment, payment, or health care operations.

7. **Communications about product, service and benefits**. The Plan may use and disclose Your PHI to tell You about possible medical treatment options, programs, or alternatives, or to tell You about health related products or services, including payment or coverage for such products or services, that may be of interest to You, provided the Plan does not receive financial remuneration for making such communications. The Plan may also use Your PHI to contact You with information about benefits under the Plan, including certain communications about Plan networks, health plan changes, and services or products specifically related to a health condition You may have. The Plan may use and disclose Your PHI to contact You to provide reminders, such as annual check-ups, or information about treatment alternatives or other health related benefits and services that may be of interest to You.

8. **Communications with individuals involved in Your treatment and/or Plan payment**. Although the Plan will generally communicate directly with You about Your claims and other Plan related matters that involve Your PHI, there may be instances when it is more appropriate to communicate about these matters with other individuals about Your health care or payment. This may include family, relatives, or close personal friends (or anyone else you may choose to designate).

   With Your authorization, the Plan may use or disclose Your PHI to a relative or other individual who You have identified as being involved in Your health care that is directly relevant to their involvement in these matters. If You are not present, the Plan's disclosure will be limited to the PHI that directly relates to the individual's involvement in Your health care. The Plan may also make such disclosures to these persons if: (i) You are given the opportunity to object to the disclosures and do not do so. This verbal permission will only cover a single encounter, and is not a substitute for a written authorization; or (ii) if the Plan reasonably infers from the circumstances that You do not object to disclose to these persons, such as if You are not present or are unable to give Your permission and the Plan determines (based on its professional judgment) that the use or disclosure is in Your best interest. The Plan will not need Your written authorization to disclose Your PHI when, for example, You are attempting to resolve a claims dispute with the Plan and You orally inform the Plan that Your spouse will call the Plan for additional discussion relevant to these matters. The Plan may also provide limited PHI to Your former spouse to the extent reasonably required to continue Your former spouse on Your Plan, including information related to cost, payment, benefits, and the coverage of any joint children.

   The Plan may also use or disclose your name, location, and general condition (or death) to notify, or help to notify, persons involved in Your care about Your situation. If You are incapacitated or in an emergency, the Plan may disclose Your PHI to persons it reasonably believes to be involved in Your care (or payment) if it determines that the disclosure is in Your best interest.

9. **Research**. The Plan may use or disclose PHI for research purposes, provided that the researcher follows certain procedures to protect Your privacy. To the extent it is required by State law, The Plan will obtain Your consent for a disclosure for research purposes.

10. **De-Identified Data**. The Plan may create a collection of information that can no longer be traced back to You. This information does not contain individually identifying information.

11. **Business Associates**. The Plan may disclose Your PHI to a "business associate." The Plan's business associates are the individuals and entities the Plan engages to perform various duties on behalf of the Plan, or to provide services to the Plan. For example, the Plan's business associates might provide claims management services or utilization reviews. Business associates are permitted to receive, create, maintain, use, or disclose PHI, but only as provided in the Privacy Rule, and only after agreeing in writing to appropriately safeguard Your PHI pursuant to a business associate agreement.

12. **Other Uses and Disclosures**. The Plan may make certain other uses and disclosures of Your PHI without Your authorization:

    a. The Plan may use or disclose Your PHI for any purpose required by federal, state, or local law. For example, The Plan may be required by law to use or disclose Your PHI to respond to a court order.

    b. The Plan may disclose Your PHI in the course of a judicial or administrative proceeding (for example, to respond to a subpoena or discovery request.)

    c. The Plan may use or disclose Your PHI for public health activities that are permitted or required by law, including reporting of disease, injury, birth and death, and for public health investigations.

    d. The Plan may disclose Your PHI to a public or private organization authorized to assist in disaster relief efforts. The Plan may use or disclose Your PHI to help notify a relative or other individual who is responsible for Your health care, of your location, general condition, or death. In such situations, if You are present and able to give Your verbal permission, the Plan will only use or disclose Your PHI with Your permission. This verbal permission will only cover a single encounter and is not a substitute for a written authorization. If You are not present or are unable to give Your permission, the Plan will use or disclose Your PHI only if it determines (based on its professional judgment) that the use or disclosure is in Your best interest.

    e. The Plan may disclose Your PHI to a health oversight agency for activities authorized by law. The relevant agencies include governmental units that oversee or monitor the health care system, government benefit and regulatory programs, and compliance with civil rights laws. The relevant activities include conducting audits, investigations, or civil or criminal proceedings.

    f. Under limited circumstances (such as required reporting laws or in response to a grand jury subpoena), the Plan may disclose Your PHI to the appropriate law enforcement officials for law enforcement purposes.

    g. The Plan may disclose Your PHI to coroners, medical examiners, and funeral directors as necessary for them to carry out their duties. If You are an organ donor, the Plan may disclose Your PHI to organ procurement or organ, eye, or tissue transplantation organizations, as necessary to facilitate organ or tissue donation and transplantation.

    h. The Plan may use or disclose Your PHI to avert a serious threat to Your health or safety, or to the health and safety of others. Any such disclosure will be made to someone who would be able to help prevent the threat.

    i. The Plan may disclose Your PHI, if You are in the Armed Forces, for activities deemed necessary by appropriate military command authorities, for determination of benefit eligibility by the Department of Veterans Affairs, or to foreign military authorities if You are a member of that foreign military service. The Plan may disclose Your PHI to authorized federal officials for conducting national security and intelligence activities (including for the provision of protective services to the President of the United States) or to the Department of State to make medical suitability determinations. If You are an inmate at a correctional institution, then under certain circumstances the Plan may disclose Your PHI to the correctional institution.

    j. The Plan may disclose Your PHI to the extent necessary to comply with laws concerning workers' compensation or to comply with similar programs that are established by law and provide benefits for work-related injuries or illness.

    k. The Plan may disclose Your PHI, consistent with applicable federal and state laws, if the Plan believes that You have been a victim of abuse, neglect, or domestic violence. Such disclosure will be made to the governmental entity or agency authorized to receive such information.

    l. The Plan will disclose Your PHI to the Secretary of the Department of Health and Human Services, when required to do so, to enable the Secretary to investigate or determine the Plan's compliance with HIPAA and the Privacy Rule.

E. Your rights regarding Your Protected Health Information

You have the following rights relating to Your PHI:

1. **Right to access, inspect, and copy**. You have the right to look at or get copies of Your PHI maintained by the Plan that may be used to make decisions about Your Plan eligibility and benefits, with limited exceptions. The Plan may require You to make this request in writing to the Privacy Officer listed at the end of this Notice. Generally, the Plan will respond to Your request within 30 days after the Plan receives it; if more time is needed, the Plan will notify You within the original 30-day period. The Plan may deny Your request to inspect and copy in certain very limited circumstances. The Privacy Rule contains a few exceptions to Your right to inspect and copy Your PHI maintained by the Plan. You do not have the right to inspect or copy, among other things, psychotherapy notes or materials that are compiled in anticipation of litigation or similar proceedings. If Your written request is denied, You will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If the information You request is maintained electronically, and You request an electronic copy, the Plan will provide a copy in the electronic form and format You request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, the Plan will work with You to come to an agreement on form and format. If we cannot agree on an electronic form and format, the Plan will provide You with a paper copy. You have a right to choose to receive a copy of all or of only portions of your PHI. The Plan may charge a fee for copying or mailing Your PHI for You but may waive that charge depending on Your circumstances. If you make a request in advance, the Plan will provide You with an estimate of the cost of copying or mailing the requested information.

2. **Right to request an amendment of Your PHI**. If You believe that there is a mistake or missing information in a record of Your PHI held by the Plan or one of its vendors, You may request in writing, that the record be corrected or supplemented. You have the right to request an amendment for as long as the PHI is kept by or for the Plan. Your request must be in writing and must include a reason or explanation that supports Your request. The Plan, or someone on its behalf, will respond usually within 60 days of receiving Your request. The Plan may deny the request if it is not in writing, it is determined that the PHI is correct and complete, not part of the PHI kept by or for the Plan, not created by the Plan or its vendors, and/or not part of the Plan's or vendor's records (unless the person or entity that created the information is no longer available to make the amendment), or not part of the information which You would be permitted to inspect and copy. All denials will be made in writing. Any denial will include the reasons for denial and explain Your rights to have the request and denial, along with any statement in response that You provide, appended to Your PHI. If the Plan denies Your request for an amendment, You may file a written statement of disagreement, which the Plan may rebut in writing. The denial, statement of disagreement, and rebuttal will be included in any future disclosures of the relevant PHI. If Your request for amendment is approved, the Plan or the vendor, will change the PHI and inform You of the change and inform others that need to know about the change. If the Plan approve Your request, the Plan will include the amendment in any future disclosures of the relevant PHI.

3. **Right to request and receive an accounting of disclosures**. You have a right to receive a list of routine and non-routine disclosures that Plan has made of Your PHI. This right includes a list of when, to whom, for what purpose and what portion of your PHI has been released by the Plan and its vendors. This does not include a list of disclosures for treatment, payment, health care operations, and certain other purposes (such as disclosures made for national security purposes, to law enforcement officials, or correctional facilities). If the PHI disclosed is not an "electronic health record," the accounting will include disclosures for the six (6) years prior to the date of your request. In this case, as noted above, the accounting is not required to include all disclosures. If the PHI disclosed is an "electronic health record," the accounting will include disclosures up to three (3) years before the date of Your request. Your request for the accounting must be made in writing. Your request must include the time frame that You would like the Plan to cover (this may be no more than six (6) years before the date of the request). You will normally receive a response to Your written disclosure for this accounting within 60 days after your request is received. There will be no charge for up to one such list each year but there may be a charge for more frequent requests. The Plan 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.

4. **Right to request restrictions**. You have the right to request that the Plan restrict how it uses or discloses Your PHI for treatment, payment, or health care operations. You also have the right to request a limit on the PHI about You that the Plan discloses to someone who is involved in Your care or the payment of Your care, like a family member or friend. The Plan will consider Your request but generally is not legally bound to agree to the request for restriction. However, the Plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which You, or another person on Your behalf, has paid the health care provider or other covered entity involved in full. Your request must be in writing. In Your request, You must tell the Plan (1) what information You want to limit; (2) whether You want to limit the Plan's use, disclosure, or both; and (3) to whom You want the limits to apply, for example, disclosure to Your spouse. If the Plan does agree to Your restriction it must comply with the agreed to restriction, except for purposes of treating You in a medical emergency.

5. **Right to choose how the Plan contacts You**. You have the right to request that the Plan communicate with You about Your PHI by alternative means or to an alternative location. For example, you may request that the Plan only contact you at designated address or phone number. Your request must be in writing. In Your request, You must tell us how or where You wish to be contacted. The Plan will make a reasonable accommodation of Your request for confidential communication.

6. **Right to request a copy of this Notice in an alternative format**. You are entitled to receive a printed copy of this Notice at any time as well as a non-English translation. You may ask the Plan to give You a paper or electronic 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. Contact the Plan using the information listed at the end of this Notice to obtain an alternative copy of this Notice.

F. Complaints

If You believe Your privacy rights have been violated, 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, send a written complaint to the Privacy Officer listed at the end of this Notice. The Plan will not retaliate against You for filing a complaint, and You will not be penalized in any other way for filing a complaint.

G. Contact Information for questions

If You have questions about this Notice or would like more information about the Plan's privacy practices, please contact:

Privacy Officer
Minnesota Management and Budget / SEGIP
400 Centennial Office Building
658 Cedar Street
Saint Paul, Minnesota 55155
(651) 355-0100
segip.mmb@state.mn.us

Minnesota Management and Budget

NOTICE OF COLLECTION OF PRIVATE DATA
(September 2, 2017)

Minnesota Management and Budget (MMB) administers the State Employee Group Insurance Program (SEGIP). This notice explains why we are requesting the private data about You, Your spouse, and dependents, how we will use it, who will see it, Your obligation to provide the data, and the result of providing or not providing the requested data.

What data will we use?

We will use the data You provide us at this time, as well as data previously provided us, about You, Your spouse, and dependents. If You provide any data that is not necessary, we will not use it for any purpose.

Why we ask You for this data?

We ask for this data so that we can successfully administer employee group health benefits that are self-insured. This data is used to process Your request to add, change, or drop coverage for Yourself and Your spouse or dependents. The requested data also helps us to determine eligibility, to identify, and to contact You and Your spouse and dependents. The data is used to administer programs, develop new programs, to determine if programs are properly managed and meet member needs, and to comply with federal and state laws and rules.

Do You have to answer the questions we ask?

You are not required to provide any of the data but certain data must be collected, or we may be unable to administer the programs or provide You Your benefits.

What will happen if You do not answer the questions we ask?

If You do not provide the requested data, You or Your spouse and dependent may not be approved to participate in a program or may lose coverage under the program or the participation may be delayed.

Who else may see this data about You and Your spouse and dependents?

We may give data about You, Your spouse and dependents to the group health benefits that are self-insured and service providers You have chosen, as well as SEGIP's other contracted vendors, so that they may help administer the programs. We may also provide this data to the Legislative Auditor; the Department of Health; the Department of Commerce; and any law enforcement agency or other agency with the legal authority to have the data; and anyone authorized by a court order. In addition, the parents of a minor may see data on the minor unless there is a law, rule, court order, or other legally binding instrument that blocks the parent from that data.

How else may this data be used?

We can use or release this data only as stated in this notice or allowed under law unless You give us Your written permission to release the data for another purpose or to release it to another individual or entity. The data may also be used for another purpose if Congress or the Minnesota Legislature passes a law allowing or requiring us to release the data or to use it for another purpose.

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

Authorized Representative. This is a person appointed by you to act on your behalf in connection with an initial claim, an appeal of an adverse benefit determination, or both. To designate an authorized representative, you must complete and sign the "Appointment of Authorized Representative" form and return it to the Plan Manager. You should specify on the form the extent of the authorized representative's authority. This form is available by logging on to your "myHealthPartners" account at healthpartners.com.

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 their 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 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 Network Benefits and Non-Network Benefits.

Individual Calendar Year Deductible	**Network Benefits** $50	**Non-Network Benefits** $125
Family Calendar Year Deductible	**Network Benefits** $150	**Non-Network Benefits** $125 per individual

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 available to patients but which are not dentally necessary.

Eligible Dependents. Minnesota Management and 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 their employing organization, they are 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.

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 31 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 if they continue 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 (QMCSO) 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.

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.

Illness. This is a sickness or disease, including all related conditions and recurrences, requiring dentally necessary treatment.

Injury. This is an accident to the body requiring medical or dental treatment.

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 Preventive and Diagnostic Services and Orthodontic Services do not apply to the Individual Calendar Year Maximum Benefit.

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

	Network Benefits	**Non-Network Benefits**
Calendar Year Maximum Benefit	$2,000	$2,000

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 Dental Network, or dentists outside of the Network (Non-Network Benefits).

When you use Non-Network Providers, benefits may be substantially reduced and you may incur significantly higher out-of-pocket expenses. A Non-Network Provider does not usually have an agreement with HealthPartners to provide services at a discounted fee. In addition, Non-Network Benefits are restricted to our maximum amount allowed as described under the definition of Charge. Our maximum amount allowed can be significantly lower than a Non-Network Provider's billed charges. If the Non-Network Provider's billed charges are over our maximum amount allowed, you pay the difference, in addition to any required deductible and/or coinsurance.

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 Network Benefits and Non-Network Benefits.

Individual Calendar Year Deductible	**Network Benefits** $50	**Non-Network Benefits** $125
Family Calendar Year Deductible	**Network Benefits** $150	**Non-Network Benefits** $125 per individual
Calendar Year Maximum Benefit	**Network Benefits** $2,000	**Non-Network Benefits** $2,000

A. PREVENTIVE AND DIAGNOSTIC SERVICES.

The Plan covers, with certain limitations:

For this category, the Deductible and Calendar Year Maximum Benefit do not apply.

Routine dental care examinations for new and existing patients	**Network Benefits** 100% of the charges incurred, limited to twice each calendar year.	**Non-Network Benefits** 50% of the charges incurred, limited to twice each calendar year.
Dental cleaning (prophylaxis)	**Network Benefits** 100% of the charges incurred, limited to twice each calendar year.	**Non-Network Benefits** 50% of the charges incurred, limited to twice each calendar year.
Periodontal maintenance cleaning	**Network Benefits** 100% of the charges incurred, limited to four each calendar year.	**Non-Network Benefits** 50% of the charges incurred, limited to four each calendar year.

Professionally applied topical fluoride (other than silver diamine fluoride)	**Network Benefits** 100% of the charges incurred, limited to once each calendar year for covered persons under age 19.	**Non-Network Benefits** 50% of the charges incurred, limited to once each calendar year for covered persons under age 19.
Silver diamine fluoride	**Network Benefits** 100% of the charges incurred, limited to twice per tooth each calendar year.	**Non-Network Benefits** 50% of the charges incurred, limited to twice per tooth each calendar year.
Bitewing x-rays	**Network Benefits** 100% of the charges incurred, limited to once each calendar year.	**Non-Network Benefits** 50% of the charges incurred, limited to once each calendar year.
Full mouth or panoramic x-rays	**Network Benefits** 100% of the charges incurred, limited to once every three years.	**Non-Network Benefits** 50% of the charges incurred, limited to once every three years.
Other x-rays, except x-rays provided in connection with orthodontic diagnostic procedures and treatment	**Network Benefits** 100% of the charges incurred.	**Non-Network Benefits** 50% of the charges incurred.
Space maintainers for lost primary teeth (fixed or removable appliances designed to prevent adjacent and opposing teeth from moving)	**Network Benefits** 100% of the charges incurred, for covered persons under age 19.	**Non-Network Benefits** 50% of the charges incurred, for covered persons under age 19.
Pit and fissure sealant application and preventive resin restorations	**Network Benefits** 100% of the charges incurred, limited to one application per tooth per three-year period, for permanent molars.	**Non-Network Benefits** 50% of the charges incurred, limited to one application per tooth per three-year period, for permanent molars.
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	**Network Benefits** 100% of the charges incurred.	**Non-Network Benefits** 50% of the charges incurred.
Screening or assessments of a patient	**Network Benefits** 100% of the charges incurred, limited to twice each calendar year.	**Non-Network Benefits** 50% of the charges incurred, limited to twice each calendar year.
Oral hygiene instruction	**Network Benefits** 100% of the charges incurred. *Oral hygiene instruction is limited to once per lifetime as an independent procedure.*	**Non-Network Benefits** 50% of the charges incurred.

B. BASIC SERVICES.

The Plan covers, with certain limitations:

For this category, the Deductible applies.

Consultations	**Network Benefits** 80% of the charges incurred.	**Non-Network Benefits** 50% of the charges incurred.
Emergency treatment for relief of pain	**Network Benefits** 80% of the charges incurred.	**Non-Network Benefits** 50% of the charges incurred.
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	**Network Benefits** 80% of the charges incurred.	**Non-Network Benefits** 50% of the charges incurred.
posterior composites (white fillings on bicuspids and molars)	**Network Benefits** 80% of the charges incurred.	**Non-Network Benefits** 50% of the charges incurred.
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– surgical and non-surgical extraction	**Network Benefits** 80% of the charges incurred.	**Non-Network Benefits** 50% of the charges incurred.
Periodontics (Gum Disease) – surgical and non-surgical treatment	**Network Benefits** 80% of the charges incurred, limited to once in two years. *Full mouth debridement is limited to once per lifetime. Localized delivery of anti-microbial agents are not covered.*	**Non-Network Benefits** 50% of the charges incurred, limited to once in two years.
Endodontics (Root canal therapy)	**Network Benefits** 80% of the charges incurred. *Endodontics (root canal therapy) is limited to once per tooth per lifetime.*	**Non-Network Benefits** 50% of the charges incurred.

C. SPECIAL SERVICES.

The Plan covers, with certain limitations:

For this category, Deductible applies.

	Network 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	**Network Benefits** 80% of the charges incurred.	**Non-Network Benefits** 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.

For this category, the Deductible applies.

Bridges	**Network Benefits** 80% of the charges incurred.	**Non-Network Benefits** 50% of the charges incurred.
Dentures	**Network Benefits** 80% of the charges incurred.	**Non-Network Benefits** 50% of the charges incurred.
Partial Dentures	**Network Benefits** 80% of the charges incurred.	**Non-Network Benefits** 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.

For this category, the Deductible applies.

Network Benefits	**Non-Network Benefits**
80% 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.

Dental Implant Services Calendar Year Maximum

Network Benefits	**Non-Network Benefits**
$2,000	$2,000

The dental implant services calendar year maximum under the Network 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.

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

F. EMERGENCY DENTAL CARE SERVICES.

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

	Network Benefits	**Non-Network Benefits**
	Coverage level is the same as corresponding Network 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 orthodontic services with certain limitations: 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 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, the Deductible does not apply

	Network Benefits	**Non-Network Benefits**
	80% of the charges incurred.	50% of the charges incurred.
Lifetime Maximum	**Network Benefits**	**Non-Network Benefits**
	$3,000	$3,000

Benefits applied to any previous Contract Year Maximum Benefit for orthodontia will be applied toward the Orthodontic Services Lifetime Maximum. The $3,000 Orthodontic Services Lifetime Maximum is effective for treatment beginning on or after 1/1/20.

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, (including chipping or fractures), 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 and localized delivery of anti-microbial agents.
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 Network Benefits, treatment, procedures or services which are not provided by a network dentist or other authorized Network 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 their 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 calendar 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. ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE, AND CONVERSION

A. ELIGIBILITY

Minnesota Management and 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.

B. ENROLLMENT AND EFFECTIVE DATE

The initial effective date of coverage is the 35th calendar day after the first day of employment, rehire or reinstatement. The initial effective date of coverage for an employee whose eligibility has changed is the date of the change provided the employee has been employed for 35 consecutive days. 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 their 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 SEGIP receives the 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.

C. CONVERSION

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

D. OFF-CYCLE ENROLLMENT

A covered person and their covered dependents will be allowed to make an enrollment choice outside of the dental open enrollment period or initial period of eligibility 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. The dental claim administrator participating in the SEGIP is placed into rehabilitation or liquidation, or is otherwise unable to provide the services specified in the SB.

2. Any dental claim administrator participating in the SEGIP loses all or a portion of its dental provider network 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 dental claim administrator participating in the SEGIP terminates or is terminated from participation in the Program.

4. A covered employee moves to a location outside of the service area if access to dental coverage is impacted.

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 dental 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 dental 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 dental plan administrator documenting the loss of coverage.

   c. When a covered employee acquires their first dependent child.

7. A former legislator and their 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.

VIII. CONTINUATION OF GROUP DENTAL COVERAGE

You have the right to temporary extension of coverage under the State Employees Group Insurance Program (the Plan). The right to continuation coverage was created by the federal Public Health Service Act (PHSA), as well as by certain state laws. Continuation coverage may become available to You and to qualified dependents who are covered under the Plan when You would otherwise lose Your group health coverage.

This notice generally explains continuation coverage, when it may become available to You and Your qualified dependents, and what You need to do to protect the right to receive it.

The Plan Administrator is the State of Minnesota, Minnesota Management & Budget, Employee Insurance. The Plan Administrator is responsible for administering continuation coverage.

Continuation Coverage
Continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. In most cases, You have 60 days from the date of the qualifying event to select continuation of coverage. Continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect continuation coverage must pay the full cost of coverage plus a 2% administration fee based on the cost of Your premium from the date of coverage would have terminated. (The 2% fee is waived in the case of disabled employees who elect such coverage.)

If You are an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because either one of the following qualifying events happens:
1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than their gross misconduct; or
4. You become divorced from Your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than their gross misconduct; or
4. The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the State of Minnesota, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is continuation coverage available?

The Plan will offer continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or commencement of a proceeding in bankruptcy with respect to the employer, the Plan Administrator must be notified of the qualifying event within 30 days following the date coverage ends.

You must give notice of some qualifying events

For other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), You must notify the Plan Administrator in writing. The Plan requires You to notify the Plan Administrator within 60 days of the qualifying event occurs. You must send this notice to: Minnesota Management and Budget, Employee Insurance, 658 Cedar Street, St. Paul, MN, 55155. Failure to provide notice may result in the loss of Your ability or the ability of Your dependent to elect continuation coverage.

How is continuation coverage provided?

Once the Plan Administrator receives timely notice that a qualifying event has occurred, continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect continuation coverage. Covered employees may elect continuation coverage on behalf of their spouses, and parents may elect continuation coverage on behalf of their children. For each qualified beneficiary who elects continuation coverage, that coverage will begin on the date that Plan coverage would otherwise have been lost.

Continuation coverage is a temporary continuation of coverage.

- When the qualifying event is a dependent child losing eligibility as a dependent child, continuation of medical coverage lasts for up to 36 consecutive months.

- When the qualifying event is the death of the employee or divorce, continuation of medical coverage may last indefinitely.

- When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 consecutive months before the qualifying event, continuation of medical coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

- Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, continuation coverage generally lasts for only up to a total of 18 consecutive months. This 18-month period of continuation coverage can be extended if a second qualifying event occurs.

Second qualifying events

1. ***Extension of 18-month period of continuation coverage***
   If You or a Qualified Beneficiary experiences another qualifying event while receiving 18 months of continuation coverage, the spouse and dependent children in Your family can get additional months of health continuation coverage, up to a combined maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension is available to the spouse and dependent children if the employee or former employee dies, gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. **In all of these cases, You must notify the Plan Administrator of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: Minnesota Management and Budget, Employee Insurance, 658 Cedar Street, St. Paul, MN, 55155.**

2. ***Disability extension of 18-month period of continuation coverage***
   If You or a qualified dependent covered under the Plan is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, You and Your qualified dependents can receive up to an additional 11 months of health continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of continuation coverage. This notice should be sent to: the Minnesota Management and Budget, Employee Insurance, 658 Cedar Street, St. Paul, MN, 55155.

Continuation coverage for employees who retire or become disabled
There are special rules for employees who become disabled or who retire. It is Your responsibility to contact Your agency's Human Resources office or Minnesota Management & Budget to become informed about those rules.

If You have questions

If You have questions about Your continuation coverage, You should contact Minnesota Management and Budget, Your agency's Human Resources office, or You may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at dol.gov/ebsa.

Keep the Employer Informed of Address Changes

In order to protect Your rights and those of Your qualified dependents, You should keep the Employer informed of any changes in Your address and the addresses of qualified dependents. You should also keep a copy, for Your records, of any notices You send to the Employer or the Plan Administrator.

Cost Verification

Your employer will provide You or Your eligible dependents, upon request, written verification of the cost of continuation coverage at the time of eligibility or at any time during the continuation period.

Special Second Election Period

Special continuation rights apply to certain employees who are eligible for the health coverage tax credit. These employees are entitled to a second opportunity to elect continuation coverage for themselves and certain family Members (if they did not already elect continuation coverage) during a special second election period. This election period is the 60-day period beginning on the first day of the month in which an eligible employee

becomes eligible for the health coverage tax credit, but only if the election is made within six months of losing coverage. Please contact the Plan Administrator for additional information.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If You have questions about these new tax provisions, You may call the Health Care Tax Credit Customer Tax Credit Customer Contact Center toll-free at 1/866-628-4282.

Retirement

An 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 health and dental coverage with the SEGIP by filling out the proper forms with their agency within 30 days after the effective date of their retirement.

If a retiring employee fails to make a proper election within the 30-day time period, the retiring Employee may continue coverage for up to 18 months in accordance with state and federal law. See item 13 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 for You and/or Your dependents will terminate on the earliest of the following dates, except that coverage may be continued in some instances as specified in Continuation of Coverage.

a) For You and Your dependents, the date that either HealthPartners Dental or Minnesota Management & Budget terminates the Plan.

b) For You and Your dependents, the last day of the month in which You retire, unless You and Your dependents elect to maintain coverage under this Plan or a separate Medicare contract.

c) For You and Your dependents, the last day of the month in which Your eligibility under this Plan ends.

d) For You and Your dependents, following the receipt of a written request, the coverage will end on the last day of the month in which a life event occurred. 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:

   i) loss of dependent status of a sole dependent;
   ii) death of a sole dependent;
   iii) divorce;
   iv) change in employment condition of an employee, spouse, or a dependent who is covered under another Employer's plan (date of life event is based on the date of change in employment status, not eligibility for insurance coverage);
   v) a significant change of spouse's or a dependent's insurance cost or existing insurance coverage (for example, coverage decrease or addition of a benefit package; and
   vi) Open Enrollment.

e) Consistent with Your ability to choose a Plan on the basis of where You live or work. For an Enrollee, the date 30 days after notice by **HealthPartners Dental** when the Enrollee no longer resides within the service area. For the purposes of this section, a dependent's address is considered to be the same as Your address when attending an accredited school on a full-time basis, even though the student may be located outside of the service area.

f) For a child covered as a dependent, the last day of the month in which the child is no longer eligible as a dependent, unless otherwise specified by MMB.

g) For a dependent, the effective date of coverage, if the employee or their dependent knowingly makes fraudulent misstatements regarding the eligibility of the dependent for coverage.

h) For an enrollee who is directly billed by the MMB, the last day of the month for which the last full premium was paid, when the enrollee fails to pay the premium within 30 days of the date the premium was billed or due, whichever is later.

i) For an enrollee who is directly billed by **HealthPartners Dental**, the end of the month for which the last premium was paid, when the enrollee fails to pay the premium within 30 days of the date the premium is due.

j) An employee or dependent found to be ineligible will be dropped from coverage as of the date of ineligibility or, if the date of ineligibility has passed then, 30 days from the first of the next full month. If the employee or dependent was found eligible based on fraud or an intentional misrepresentation of a material fact, then the loss of coverage will be retroactive to the first day of ineligibility. If the Plan Sponsor erroneously enrolled an employee or a dependent coverage may be terminated retroactively to the first day of ineligibility if the Plan Sponsor obtains the written consent from the employee or dependent authorizing the retroactive termination of coverage.

X. CLAIMS PROVISIONS

A. PROCEDURES FOR REIMBURSEMENT OF HEALTHPARTNERS SERVICES

When you present your identification card at the time of requesting benefits from 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
   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
   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
   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.