HealthPartners®

Summary of Benefits

Hennepin County Dental Benefit Plan

HealthPartners Dental Distinctions Plan

SPD-400.27-SI-HPD-3096-22

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SPECIFIC INFORMATION ABOUT THE PLAN

Summary Effective Date: The later of January 1, 2022 and the Covered Person's effective date of coverage under the Plan.

Employer:	Hennepin County
Name of the Plan:	The Plan shall be known as the Hennepin County Dental Benefit Plan which provides employee and dependent benefits.
Address of the Plan:	Hennepin County Government Center A400 300 South 6th Street Minneapolis, MN 55487-0040 612-348-7855
Group Number:	3096
Plan Year:	The period beginning on each January 1 in which the provisions of the Plan are in effect.
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.)	Hennepin County
Agent for Service of Legal Process:	General Counsel for Hennepin County
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.)	For purposes of determining eligibility and enrollment, and for funding claims paid and all related activities and responsibilities under the Plan, Hennepin County is the named fiduciary. Solely for purposes of determining coverage of claims, HealthPartners Administrators, Inc. is the named fiduciary.
Funding:	Claims under the Plan are paid from the general assets of the Employer.
Plan Manager: (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 952-883-6000
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

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

ABOUT HEALTHPARTNERS AND YOUR EMPLOYER

HealthPartners Administrators, Inc. ("HPAI"). HPAI ("Plan Manager") is a third party administrator (TPA). All references to "HealthPartners" throughout this Summary mean HPAI.

Employer ("Plan Sponsor"). The Employer 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 this Summary of Benefits ("Summary"). The Plan Sponsor has contracted with HPAI to provide access to its Network of dental care providers, claims processing 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 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 employ 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 employ or to interfere with the Covered Employee's right to terminate his or her employment at any time.

RESPONSIBILITIES OF COVERED PERSONS

- Read this Summary and the enrollment materials completely and comply with the stated rules and limitations
- Contact providers to arrange for necessary dental appointments.
- Pay any applicable copayments, deductibles and contributions as stated in this Summary and the Benefits Chart.
- Identify yourself as a Covered Person by presenting your identification card whenever you receive covered services under
- the Plan.

RIGHTS UPON TERMINATION OR AMENDMENT OF THIS PLAN

For a summary of Plan provisions governing benefits, rights and obligations of participants and beneficiaries under the Plan on termination of the Plan or amendment or elimination of benefits under the Plan, please consult your Employer.

INTRODUCTION TO THE SUMMARY OF BENEFITS

SUMMARY OF BENEFITS ("SUMMARY")

This Summary is your description of the Employer's Dental Benefit Plan ("the Plan"). It describes the Plan's benefits and limitations. Attached to this Summary is a Benefits Chart which is incorporated and fully made a part of this Summary. It describes the amounts of payments and limits for the coverage provided under this Summary. Refer to your Benefits Chart for benefits and the amount of coverage applicable to a particular benefit.

This Summary 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 Summary have special meanings and are specifically defined in this Summary and the Benefits Chart. Your Summary 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.

DENTAL CLAIMS ADMINISTRATIVE SERVICES AGREEMENT ("ASA")

This Summary, the Benefits Chart(s), any Amendments, together with the ASA between the Plan Sponsor and HPAI, as well as any other documents referenced in the ASA, constitute the entire agreement between HPAI and the Plan Sponsor. The ASA is available for inspection at your Employer's office or at HealthPartners' home office, at 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

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.

ASSIGNMENT OF BENEFITS

You may not, in any way, assign or transfer your rights or benefits under the Plan. In addition, you may not, in any way, assign or transfer your right to pursue any causes of action arising under this Plan including, but not limited to, causes of action for denial of benefits under this Plan.

CONTRIBUTIONS

This Summary is conditioned on regular receipt of Covered Persons' contributions toward the coverage provided by this Summary. 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.

AMENDMENTS TO THIS SUMMARY

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

CONFLICT WITH EXISTING LAW

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

HOW TO USE THE PLAN

This Summary 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. **Network Providers are available to view free of charge by logging on to your "*my*HealthPartners" account at healthpartners.com. If you need assistance locating a dentist or other dental care providers in your Network, please contact Member Services.**

Non-Network Providers. These are licensed dentists or other dental care providers, or facilities not participating as Network Providers. Services received from Non-Network Providers will be covered at the Non-Network Benefit level. There are limited exceptions as described in this Summary and the Benefits Chart.

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. There are limited exceptions as described in this Summary and the Benefits Chart. **You must verify that your provider participates with the Network each time you receive services.**

Network. These are the dental care providers and facilities contracted to provide services for this Plan.

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 his or her designee makes coverage determinations and makes final authorization for certain covered services. Coverage determinations are based on established dental policies, which are subject to periodic review and modification by the Plan Manager'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 952-883-5000 or 800-883-2177 for more information on authorization requirements.

ACCESS TO RECORDS AND CONFIDENTIALITY

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

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

- Not use or further disclose information except as listed above or as required or permitted by law;
- Ensure that any agents or subcontractors agree to the same restrictions and conditions that apply to your Employer or Plan Sponsor and that such agents and subcontractors agree to implement reasonable and appropriate security measures to protect electronic protected health information;

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

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 Plan Manager 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 Plan Manager 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 Summary and the Benefits Chart.

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.

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 "*my*HealthPartners" account at healthpartners.com.

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 Summary and the Benefits Chart.

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.

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 enrolled in the Plan

Covered Person. This is the person covered for benefits and all of his or her eligible and enrolled dependents. When used in this Summary and the Benefits Chart, "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 Summary and the Benefits Chart.

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.

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 Plan Manager's dental directors or their designees, subject to final coverage determination by the Plan Sponsor.

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

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

Eligible Dependents. These are the persons shown below. Under this Summary, a person who is considered a Covered Employee is not qualified as an eligible dependent. A person who is no longer an eligible dependent (as defined below) under the Plan may qualify for continuation of coverage within the group, as provided in the "CONTINUATION OF GROUP DENTAL COVERAGE" section of this Summary.

Please note, for Covered Dependents who do not meet the definition of either a "qualifying child" or a "qualifying relative" under Internal Revenue Code Section 152, payments made by your Employer under this Plan for Covered Services may result in taxable income to the Covered Employee. Please consult with your Employer or tax advisor regarding your individual situation.

- **Spouse.** This is a Covered Employee's current legal spouse whose marriage is valid under Minnesota law. If both spouses are covered as employees under this Summary, only one spouse shall be considered to have any eligible dependents. This includes the spouse of a retiree.

- **Child.** This is a Covered Employee's:
  - natural child, or
  - legally adopted child (effective from the date of adoption or the date placed for adoption, whichever is earlier). Date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support, or
  - child for whom the Covered Employee or the Covered Employee's legal spouse has been appointed legal guardian by a court of law up to the age state in the court appointment (if less than the age 26), or
  - step-child of the Covered Employee (that is, the child of the Covered Employee's spouse), or
  - foster child, or
  - a child covered under a valid Qualified Medical Child Support Order (QMCSO) (as the term is defined by applicable law) which is enforceable against a Covered Employee.*

  In each case the child must be either under 26 years of age or a disabled dependent, as described below. Coverage will terminate the end of the month in which the child turns age 26.

  * (A description of the procedures governing Qualified Medical Child Support Order determination can be obtained, without charge, from the Plan Sponsor.)

- **Qualified Grandchild.** This is a Covered Employee's grandchild who is a federal tax dependent of the Covered Employee and is residing full-time with the Covered Employee. The grandchild must be either under 26 years of age or a disabled dependent, as described below. Coverage will terminate the end of the month in which the dependent grandchild turns age 26.

- **Disabled Child.** This Plan covers disabled children. A disabled child is a child who is and continues to be both (a) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability and (b) chiefly dependent upon the employee for support and maintenance, provided proof of such incapacity and dependency is furnished to the Plan Manager by the employee within 30 days of the child's attainment of the limiting age and subsequently as may be required by the Plan Manager, but not more frequently than annually after the two-year period following the child's attainment of the limiting age. Any notice regarding termination of coverage due to attainment of the limiting age will notify you of this right.

- **Disabled Dependent.** This Plan covers disabled dependents. A disabled dependent is a person who is and continues to be both: (a) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and (b) chiefly dependent upon you for support and maintenance. Disabled dependents are not subject to any pre-existing condition limitations, or insurability, eligibility, or health underwriting approval.

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.

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.

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.

SERVICES NOT COVERED

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

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 primarily intended to alter the shape, appearance and function of the teeth 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, and any services intended to replace existing restorations done historically for cosmetic reasons, even if due to material failure (wear/chipping/fracture) or the presence of decay at the restorative margin.
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. General anesthesia and intravenous sedation are not covered except as indicated in the Benefits Chart.
6. Orthodontic services, except as provided in this Summary and the Benefits Chart.
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 of tooth structure or restorations), or erosion, abfraction, abrasion or realigning teeth, except as covered orthodontic services provided in this Summary and the Benefits Chart. Mandibular orthopedic appliances and bite planes are also not covered.
10. Procedures, appliances or restorations for the prevention of bruxism (grinding of teeth) or clenching.

11. 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.
    (d) replacement of space maintainers.
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 to 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 Summary and the Benefits Chart.
14. Prescription drugs and medications prescribed by a dentist. This includes gingival irrigation.
15. Services provided to the Covered Person which the Covered Person is not required to pay.
16. The portion of a billed charge for an otherwise covered service by a Non-Network Provider, which is in excess of the Plan's maximum amount allowed. Also not covered are charges or a portion of a charge which is either a duplicate charge for a service or charges for a duplicate service.
17. Services for injury or illness either (a) arising out of an injury in the course of employment and subject to workers' compensation or similar law; or (b) for which benefits are payable without regard to fault, under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance; or (c) for which benefits are payable under another policy of accident and health insurance, Medicare or any other governmental program.
18. Except where expressly addressed in the Benefits Chart, 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. Athletic mouth guards.
22. Charges for infection control, sterilization and waste disposal.
23. Charges for sales tax.
24. Treatment, procedures, or services or drugs which are provided when you are not covered under this Plan.
25. Cone beam CT capture and interpretation, except when authorized by a HealthPartners dental director, or his or her designee. The Plan does not cover cone beam CT interpretation if billed separately. The Plan also does not cover cone beam capture and interpretation for TMJ series.
26. Maxillofacial MRI, maxillofacial ultrasound and sialoendoscopy capture and interpretation.
27. Additional charges for the harvest of bone for use in autogenous grafting procedure.
28. Maxillofacial prosthetics.
29. Charges for case presentations for treatment planning or behavioral management.
30. Charges for enamel microabrasion, odontoplasty and pulpal regeneration.
31. Charges for surgical procedures for isolation of a tooth with a rubber dam.
32. Charges for fixed or removable appliances to control harmful habits such as tongue thrusting or thumb sucking.
33. Charges for cleaning and inspection of a removable appliance.
34. Services associated with non-covered services.
35. Post processing of image or image sets.
36. Caries risk assessment and documentation.
37. Charges for unspecified procedures.
38. Charges for the placement of a restorative foundation for an indirect restoration.
39. Charges for periradicular services and bone grafts or other material used in conjunction with periradicular surgery.
40. Non-dental administrative fees and charges including, but not limited to dental record preparation and interest charges.
41. Services related to a prosthetic or special restorative appliance which was installed or delivered more than 60 days after termination of coverage.
42. Onlays, veneers or partial crowns fabricated from extraorally cured composite resin or porcelain.
43. Periodontal splinting.
44. 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.
45. 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.

DISPUTES AND COMPLAINTS

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 Plan Manager's dental director. The Plan Manager's dental directors or their designees make coverage determinations of dental necessity, restrictions on access and appropriateness of treatment, and makes final authorization for covered services.

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: 952-883-5000 or 800-883-2177

CONDITIONS

COORDINATION OF BENEFITS

You agree, as a Covered Person, to permit the Plan Manager to coordinate the Plan's obligations under this Summary 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 Plan Manager'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 Plan 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 Summary 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 Plan Manager has the right to decide which facts are needed. Consistent with applicable state and federal law, the Plan Manager 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 Plan Manager 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 Plan Manager 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 Plan Manager 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 Plan Manager 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).

ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY

Benefit-eligible employees are employees who work full-time or part-time in a regular or limited duration position and whose standard hours are at least 20 hours per week. Retirees and early retirees as determined by the Plan Sponsor, are also eligible to enroll in the Plan.

ENROLLMENT

In most cases, Employees must enroll themselves and any eligible dependents within 30 days of the date they first become eligible. The employee must enroll a newly acquired dependent (such as a new spouse) within 30 days of when the new dependent is first acquired.

For eligible dependent children under the age of 3, an Employee can choose to enroll them in the plan at any time, even if it is outside the annual open enrollment period. If you elect this option and choose to enroll an eligible dependent child under the age of 3, required payments do not have to be made retroactive to the date of birth, or date of placement for adoption. Coverage for dependents enrolled in this circumstance will become effective on the first of the month following the date of application.

Children over the age of 3 must be enrolled within 30 days of the date they first become eligible, or during the annual open enrollment period.

In addition, pursuant to state law newborn infants (including a newborn grandchild of a covered grandparent) and a newly adopted child, may be covered, regardless of when notice is received by the Plan Sponsor. However, the Plan Sponsor must receive required payments, if any, from the date of eligibility for a newborn infant (including a newborn grandchild of a covered grandparent) and a newly adopted child, before benefits will be paid. You must notify the Plan Sponsor immediately of any change in eligibility of a Covered Dependent.

Late Enrollment. If you do not enroll yourself or any eligible dependents within 30 days of the date that you or your dependents first become eligible, you may enroll yourself and any eligible dependents during the annual open enrollment period. However, if your eligible dependent who is under age 26 loses dental coverage under your HealthPartners medical plan by virtue of attaining a limiting age, you may enroll that dependent for coverage under the Plan within 30 days of the dependent's loss of dental coverage under the medical plan.

There may be additional situations when you are eligible to enroll yourself and any eligible dependents after the first 30 days of eligibility. If you have any questions, contact the Plan Sponsor.

EFFECTIVE DATE

The employee's and any dependent's effective date is the first day of the month following the date of employment.

TERMINATION

A Covered Person's coverage under the Plan terminates, when any of the following events occur.

1. The contribution for coverage under the Plan is not made by the due date.
2. When a Covered Employee ceases to be eligible under the terms of this Plan, coverage for the employee and all Covered Dependents terminates on the last day of the month in which the employee's eligibility ceases, unless group continuation is elected, as described in the "CONTINUATION OF GROUP DENTAL COVERAGE" section.
3. When a Covered Dependent no longer meets the Plan's definition of eligible dependent, coverage for that dependent terminates on the last day of the month in which the dependent's eligibility ceases, unless group continuation is elected, as described in the "CONTINUATION OF GROUP DENTAL COVERAGE" section.
4. When the maximum period under the group continuation coverage described in the "CONTINUATION OF GROUP DENTAL COVERAGE" section expires for the Covered Person.

5. When the Plan terminates.
6. In the event of misrepresentation or omission of a material fact by the Covered Person regarding eligibility, enrollment, other coverage, claims or other expenses, the Plan Sponsor has the right to rescind this Summary or disenroll the Covered Person.

There is no right of conversion for Covered Persons.

CONTINUATION OF GROUP DENTAL COVERAGE

If your eligibility for group coverage under the Plan ends because of one of the qualifying events shown below you may be eligible to continue group coverage as shown below.

CONTINUATION OF GROUP DENTAL COVERAGE

1. **Qualifying Events.** Coverage under the Plan may be continued by a Covered Employee, Covered Dependent spouse and other Covered Dependents, enrolled at the time coverage would otherwise end, or a child born to or placed for adoption with the Covered Employee during the period of continuation of coverage, as a result of one of the following qualifying events:
   a. Voluntary or involuntary termination of employment (except for gross misconduct) of the Covered Employee, or layoff from employment, or reduction in hours resulting in a loss of group coverage.
   b. Death of the Covered Employee.
   c. Divorce or legal separation from the Covered Employee. A former spouse is only eligible for continuation if the spouse was covered under the Plan the day before the entry of a valid decree of dissolution of marriage.
   d. Loss of eligibility as a Covered Dependent child.
   e. Initial entitlement of the Covered Employee for Medicare.
   f. For a retired Covered Employee, spouse and other dependents, the bankruptcy filing by a former Employer, under Title XI, United States Code, on or after July 1, 1986.
2. **Duration of Continuation Coverage.** The maximum period coverage can be continued depends on the qualifying event. Continuation coverage may be terminated earlier as shown below. The maximum period of continuation coverage starts on the day of the qualifying event.
   a. Maximum period.
      (1) **Termination and reduced hours.** The maximum period of continuation coverage is 18 months. If a second qualifying event, other than the Employer's bankruptcy, occurs during the 18 months, the maximum period of continuation coverage is 36 months. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination."
      (2) **Disabled Covered Employee, Covered Dependent spouse or Covered Dependent child.** If the Covered Employee, Covered Dependent spouse or other Covered Dependent is disabled under Title II or XVI of the Social Security Act, at any time during the first 60 days of continuation coverage, the 18-month maximum continuation period may be extended to 29 months. The disabled person must notify the Plan Sponsor within 60 days of the date of determination of disability, and within the initial 18-month continuation period. If a second qualifying event (other than bankruptcy) occurs during the extended 29-month period, the maximum period of continuation coverage is 36 months. See "Disabled Employee" below, which describes your rights for coverage as a disabled employee under Minnesota law.
      (3) **Bankruptcy.** In the case of bankruptcy of a retired Covered Employee's former Employer, the maximum period of continuation coverage is until the death of the retired Covered Employee. In the case of the surviving spouse or dependent children of the retired Covered Employee, the maximum period of continuation coverage is 36 months after the death of the retired Covered Employee.
      (4) **Divorce or legal separation.** There is no maximum period of coverage for a former spouse or dependents who lose coverage due to divorce or legal separation. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination."

(5) **Death of Covered Employee.** There is no maximum period of coverage for a surviving spouse and dependents who lose coverage due to the death of the Covered Employee. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination."

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

b. **Earlier Termination.** Coverage terminates before the end of the maximum period if any of the following occurs.

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

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

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

(4) **Termination of extended coverage for disability.** In case a person receives extended (29-month) continuation coverage due to disability at the time of termination or reduced hours, the extended coverage terminates at the beginning of the month 30 days after a final determination that the person is no longer disabled. See "DISABLED EMPLOYEE" below, which describes your rights for coverage as a disabled employee under Minnesota law.

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

3. Election of Continuation Coverage.

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

b. If you wish to continue group coverage as shown above, you must apply in writing to your Employer (not the Plan Manager). You must also pay your first monthly payment within 45 days of the date you elected to continue group coverage. If your coverage was terminated because of the death of the Covered Employee, your initial payment is not due until 90 days after you receive notice of the continuation right. Thereafter, your monthly payments are due and payable at the beginning of each month for which coverage is to be continued.

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

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

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

b. Your notice must be in writing and contain at least the following information:

(1) The names of the Covered Employee and Covered Dependents;
(2) The qualifying event or disability; and
(3) The date on which the qualifying event (if any) occurred.

c. Your notice must be sent to the county's designated COBRA administrator:

121 Benefits
730 Building
730 Second Avenue South, Suite 400
Minneapolis, MN 55402-2446
1-800-300-1672

The Plan will comply with applicable federal law for a Covered Employee that is called to active military duty in the uniformed services.

DISABLED EMPLOYEE

The Plan Sponsor and the Plan agree not to terminate, suspend or otherwise restrict the participation in, or the receipt of, benefits otherwise payable hereunder, to any Covered Employee who becomes totally disabled while employed by the Employer and covered hereunder while the Plan is in force, solely due to absence caused by such total disability. The Plan Sponsor may require the Covered Employee to pay all or some part of the payment for coverage in this instance. Such payment shall be made to the Plan Sponsor by that Covered Employee.

For the purpose of this section the term "total disability" means (1) the inability of an injured or ill Covered Employee to engage in or perform the duties of the Covered Employee's regular occupation or employment within the first two years of such disability and (2) after the first two years of such disability, the inability of the Covered Employee to engage in any paid employment or work for which the Covered Employee may, by education or training, including rehabilitative training, be or reasonably become qualified.

PUBLIC EMPLOYEES

Certain retired employees of public or governmental entities and their dependents may become eligible for continued coverage upon retirement, pursuant to Minnesota Statute 471.61. If you qualify under this law, you may be required to pay the entire premium for continued coverage and will be required to notify your Employer within certain deadlines, of your intent to continue coverage.

CLAIMS PROVISIONS

PROCEDURES FOR REIMBURSEMENT OF NETWORK SERVICES

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

PROCEDURES FOR REIMBURSEMENT OF NON-NETWORK SERVICES

Proof of Loss. Claims for Non-Network services must be submitted to the Plan Manager 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 after 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 Plan Manager 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

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

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 Plan Manager'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 Plan Manager is informed of such order. This payment will discharge the Plan Manager from all further liability to the extent of the payment made.

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.

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 Plan Manager, in accordance with the terms of this Summary and other Plan documents.

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 Plan Manager 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.

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. The steps in this appeal process are outlined below.

First Level Appeal to the Plan Manager. 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 Plan Manager 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.

Final Level of Appeal. 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 Manager and submit issues, comments and additional information as appropriate to:

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

The Plan Manager 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.