Group Dental Benefit Booklet

For Employees of:
MAYO CLINIC COLLEGE OF MEDICINE & SCIENCE

2023
Freedom Standard

Language Access Services

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကသိကျိာ်ဒီး, တ၊်ကဟ့ဉ်နၤကျိာ်တ၊်မၤစ၊ၤကလိတဖဉ်နူဉ်လိၤ. ကိး 1-866-251-6744 လ၊ TTY အဂိ၊်, ကိး 711 တက့၊်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

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한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį' béésh bee hodíílnih.

Notice of Nondiscrimination Practices

Effective July 18, 2016

Blue Cross and Blue Shield of Minnesota (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and Services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language Services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these Services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these Services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at:
  Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by telephone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at:
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by telephone at:
  1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F
  HHH Building
  Washington, DC 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Questions?

Call Us

Our customer service staff is available to answer your questions.

Interpreter services are available to assist you. This includes spoken language and hearing interpreters.

Hours are Monday through Friday: 7:00 a.m. – 8:00 p.m. United States Central Time

Hours are subject to change without prior notice.

Customer Service Telephone Number	For claims and benefit inquiries call 1-888-589-2447. For all other inquiries such as member ID Cards, call 1-866-873-5943.
Interpreter Services	See Section “Language Access Services” on page 2.

Visit Us

Our staff is available to answer your questions in person.

Hours are Monday through Friday: 8:00 a.m.-5:00 p.m. United States Central Time.

Hours are subject to change without prior notice.

Edina	**Roseville**	**Duluth**
Yorkdale Shoppes 6807 York Avenue South Edina, MN 55435 952-967-2750 TDD/TTY users call 711	Crossroads of Roseville 1647B County Road B2 West Roseville, MN 55113 651-726-1100 TDD/TTY users call 711	425 W. Superior Street, Suite 1060 Duluth, MN 55802 218-529-9199 TDD/TTY users call 711

Blue Cross and Blue Shield of Minnesota Website	www.bluecrossmnonline.com
Mailing Address	Claims review requests and inquires may be mailed to the address below: Dental Claims Administration P.O. Box 69449 Harrisburg, PA 17106-9449

IMPORTANT! We issue each group member an identification (ID) card. If any of the information on your member ID Card is not correct, please contact us immediately. When receiving care, present your member ID Card to the dental care provider who is rendering the services.

A copy of our privacy procedures is available on our website at www.bluecrossmnonline.com or by calling Customer Service at 1-800-382-2000.

Table of Contents

Welcome to Blue Cross

On behalf of Blue Cross, we are pleased to welcome you as a member.

This is your dental plan member benefit booklet.

In this benefit booklet, "you" or “your" refers to the group member named on the identification (ID) card and other covered dependents. “We,” “us,” or “our” refers to Blue Cross.

Your dental plan, eligibility, notification procedures, and services/expenses that are covered and not covered are explained within this benefit booklet.

It is important that you read the entire benefit booklet carefully. It provides you with the information you need to understand your Blue Cross dental plan.

Blue Cross is the insurer and the claims administrator. This dental plan is considered fully insured. Coverage is subject to all terms and conditions of this benefit booklet, including medical necessity and appropriateness.

If you have questions about your coverage, please call our customer service at the telephone number listed on the back of your member ID Card or visit one of our customer service locations listed in section “Questions?.”

You can also log onto your Blue Cross member website at www.bluecrossmnonline.com.
Thank you for choosing Blue Cross.

Your Benefits

This benefit booklet outlines the dental coverage under this plan.

To understand your benefits, read sections “Covered Services,” “Schedule of Benefits,” and “Services that are not Covered.” The “Terms You Should Know” section provides additional information on terms and conditions used in this benefit booklet.

Dental care providers are not beneficiaries under this benefit booklet.

All coverage of benefits for dependents and all references to dependents in this benefit booklet are not applicable for group member only coverage.

Covered Services

Benefits, any applicable deductibles, and maximums are shown on the “Schedule of Benefits.”

This benefit booklet provides coverage of benefits for a pre-determined schedule of dental services. Although other dental services may be recommended, they may not be covered under this benefit booklet.

Pre-Determination

You may obtain an estimate to determine whether a dental service is a covered benefit under this benefit booklet. A pre-determination is not required but may be requested prior to the delivery of a service.

A pre-determination will provide you with information to determine whether the dental service is covered and what you may be financially responsible for paying. Coverage of benefits and any financial estimate provided by a pre-determination are estimated based on your current eligibility and benefit booklet at the time of the request.

A pre-determination may also evaluate the necessity, appropriateness, and efficacy of the use of dental care services, procedures, and facilities. The evaluation is done by a person or entity other than the attending dental care professional, for the purpose of determining the dental necessity of the services.

We review all services to verify that they are dentally necessary and that the treatment provided is the proper level of care. All applicable terms and conditions of your plan including exclusions, deductibles, copays, and coinsurance provisions continue to apply with a pre-determination.

Your actual coverage of benefits, including a final determination on coverage and payment, will be processed based on the claim submitted and your eligibility and benefit booklet at the time the dental service is performed and submitted.

Schedule of Benefits

This plan does NOT meet the minimum essential health benefit requirements for pediatric oral health as required under the Affordable Care Act. Only American Dental Association procedure codes are covered.

This benefit booklet provides benefits for dental care only. It does not pay benefits for any other type of loss.

Services shown on the "Schedule of Benefits" as covered are subject to any applicable frequency or age limitations as listed below.

Deductibles and Maximums

Deductibles	**Applies to the combination of services received from Participating Provider (in-network) and Nonparticipating Provider (out-of-network)**
Calendar Year Deductible	$25 per member $75 per family Waived for Class I services
Annual Maximums	**Applies to the combination of services received from Participating Provider (in-network) and Nonparticipating Provider (out-of-network) not to exceed $1,000 per member** The Plan Pays Up to
Calendar Year Maximum	$1,000 per member

Class I – Diagnostic/Preventive Services

Benefit Category	Participating Provider (In-Network) The Plan Pays	Nonparticipating Provider (Out-of-Network) The Plan Pays
Exams (Oral Evaluations)		
• Comprehensive	100%	100%
• Periodic	100%	100%
• Limited, Problem Focused	100%	100%
• Detailed, Problem Focused	100%	100%
Cleanings (Prophylaxis)	100%	100%
Fluoride Treatments	100%	100%
X-rays		
• Full Mouth X-Rays	100%	100%
• Bitewing X-Rays	100%	100%
• All other X-Rays	100%	100%
Sealants	100%	100%
Palliative Treatment (Emergency)	100%	100%
Space Maintainers	100%	100%

Class I – Diagnostic/Preventive Services Limitations

Benefit Category	Limitations
Exams (Oral Evaluations)	• Comprehensive and periodic – 2 of these services per 12 months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the covered person is absent from the office for 3 or more year(s) • Limited problem focused and consultations – 1 of these services per dental provider per covered person per 12 months • Detailed problem focused – 1 per dental provider per covered person per 12 months
Cleanings (Prophylaxis)	• 2 per 12 months • One (1) additional for covered persons under the care of a medical professional during pregnancy
Fluoride Treatments	• Topical application: 1 per 12 months under age 14
X-rays	• Full mouth x-rays – 1 every 5 calendar year(s) • Bitewing x-rays – 1 set(s) per 12 months under age 19 and 1 set(s) per 18 months age 19 and older • Intraoral films: ▪ Occlusal 2 per 12 months under age 8 ▪ Periapical 4 per 12 months
Sealants	• 1 per tooth per 3 calendar year(s) under age 16 on the permanent first and second molars

Benefit Category	Limitations
Space Maintainers	• 1 per 5 year period for covered persons under age 14 when used to maintain space as the result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop

Class II – Basic Services

Benefit Category	Participating Provider (In-Network) The Plan Pays	Nonparticipating Provider (Out-of-Network) The Plan Pays
Basic Restorative (Fillings)		
• Amalgams	80%	80%
• Anterior resins	80%	80%
• Posterior resins	80%	80%
Repairs		
• Denture repairs	80%	80%
• Fixed denture repairs	80%	80%
• Crown repairs	80%	80%
• Recementation	80%	80%
Replacements		
• buildups, Post and Cores	80%	80%
• Prefabricated stainless steel crowns	80%	80%
Denture Adjustments		
• Denture relining and rebasing	80%	80%
• Other denture adjustments	80%	80%
Simple Extractions	80%	80%
Complex Oral Surgery	80%	80%
Anesthesia		
• General Anesthesia	80%	80%
• IV sedation	80%	80%
• Nitrous Oxide	80%	80%
Surgical Periodontal Treatment	50%	50%
Non-Surgical Periodontics		
• Periodontal maintenance	50%	50%
• Full mouth debridement	50%	50%
• Scaling and root planing	50%	50%

Benefit Category	Participating Provider (In-Network) The Plan Pays	Nonparticipating Provider (Out-of-Network) The Plan Pays
Endodontics		
• Pulpal therapy	50%	50%
• Root canal treatment	50%	50%

Class II – Basic Services Limitations

Benefit Category	Limitations
Basic Restorative	• Restorative services only when they are not, and cannot be made, serviceable: ▪ Not within 24 months of previous placement of any basic restoration
Repairs	• Recementation – 1 per 3 calendar year(s) • Recementation during the first 12 months following insertion of any preventive, restorative or prosthodontic service by the same dental provider is included in the preventive, restorative or prosthodontic service benefit
Replacement	• Prefabrication stainless steel crowns – 1 per tooth, per lifetime for covered persons under age 14 • Restorative services only when they are not, and cannot be made, serviceable: ▪ Buildup, post, and core – not within 5 calendar year(s) of previous placement of any of the procedures in this category
Denture Adjustments	• Denture relining, rebasing or adjustments are considered part of the denture charges if provided within 6 months of the insertion by the same dental provider. Subsequent denture relining or rebasing limited to 3 calendar year(s) thereafter
General anesthesia and IV sedation	• A total of 60 minutes per session • Inhalation of nitrous oxide for covered persons under age 13 • Non-intravenous conscious sedation for covered persons under age 13 when medically necessary
Surgical Periodontal Treatment	• Surgical periodontal procedures – 1 per 36 months per area of the mouth • Guided tissue regeneration – 1 per tooth per lifetime
Non-Surgical Periodontics	• Full mouth debridement – 1 per lifetime • Periodontal maintenance following active periodontal therapy – 2 per 12 months in addition to routine prophylaxis • Periodontal scaling and root planning – 1 per 24 months per area of the mouth
Endodontics	• Pulpal therapy – 1 per primary tooth per lifetime only when there is no permanent tooth to replace it. • Root canal retreatment – 1 per tooth per lifetime

Class III – Major Services

Benefit Category	Participating Provider (In-Network) The Plan Pays	Nonparticipating Provider (Out-of-Network) The Plan Pays
Inlays, Onlays, Crowns	50%	50%
Prosthetics (Dentures)		
• Removable dentures	50%	50%
• Fixed partial dentures	50%	50%
Temporomandibular Disorder/ Reconstructive Surgery	50%	50%

Class III – Major Services Limitations

Benefit Category	Limitations
Inlays, Onlays, Single Crowns	Restorative services only when they are not, and cannot be made, serviceable: • Not within 5 calendar year(s) of previous placement of any of the procedures in this category
Prosthetics	Restorative services only when they are not, and cannot be made, serviceable: • Replacement of natural tooth/teeth in an arch - not within 5 calendar year(s) of a fixed partial denture, full denture or partial removable denture
Reconstructive Surgery	• Congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including Orthodontic treatment) only when related to services that are scheduled or initiated prior to the covered person turning age 19 • Dental reconstructive surgical services when such dental service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent under age 19 because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician

Other Limitations
An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure that is less costly than the treatment recommended by the dental provider. An ABP does not commit the covered person to the less costly treatment. However, if the covered person and the dental provider choose the more expensive treatment, the covered person is responsible for the additional charges beyond those allowed under the ABP.

Blue Cross provides access to the United Concordia Advantage Plus AXS national network. United Concordia Companies, Inc. is an independent company providing dental benefit management services and access to the Advantage Plus AXS network. When you choose an in-network dental provider, you will receive a higher benefit level with the greatest savings.

Services that are not Covered

No benefits will be provided for services, materials, or charges detailed under “Schedule of Exclusions” unless defined within the “Schedule of Benefits” section of the benefit booklet.

Referrals are not required. Your dental care provider may suggest that you receive treatment from a specific provider or receive a specific treatment.

Even though your provider may recommend or provide written authorization for a referral for certain services, the dental care provider may be a nonparticipating provider or the recommended services may be excluded or limited.

When these services are referred or recommended, a written authorization from your provider does not override any provisions in the “Schedule of Benefits” or the “Schedule of Exclusions.”

No payment of benefits will be allowed under this plan for services you have already received prior to the effective date specified in the lower right-hand corner of the front cover.

Schedule of Exclusions

Services or supplies that are not dentally necessary are not covered.

Except as specifically provided in this booklet, no program payment will be made for services or charges for examinations, materials or products that are not listed as a Covered Service in the “Schedule of Benefits.” Additionally, no plan payment will be made for the exclusions listed in this section.

The following services, supplies, or charges are excluded.

Services and Procedures

1. Those specifically listed on the “Schedule of Benefits” as “Not Covered” or plan pays”0%”.
2. For plaque control programs, tobacco counseling, oral hygiene, and dietary instructions.
3. Preventive restorations.
4. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the “Schedule of Benefits.”
5. Services and/or appliances that alter the vertical dimension to restore tooth structure lost from attrition, erosion or abrasion, appliances, or any other method. For example (but not limited to):
    a. Full-mouth rehabilitation
    b. Splinting
    c. Fillings
6. Periodontal splinting of teeth by any method.
7. Replacement or repair of lost, stolen, or damaged prosthetic or orthodontic appliances.
8. For duplicate dentures, prosthetic devices, or any other duplicative device.
9. For prosthetic services if such services replace one (1) or more teeth missing prior to covered person’s eligibility under this benefit booklet. For example (but not limited to):
    a. Full or partial dentures
    b. Fixed bridges
10. Orthodontic services, supplies, and appliances, are not covered unless otherwise noted.
11. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the “Schedule of Benefits,” if applicable.

Other Expenses and Fees

1. For treatment of fractures and dislocations of the jaw.
2. For treatment of malignancies or neoplasms.
3. For treatment and appliances for bruxism (night grinding of teeth).
4. Elective procedures. For example, (but not limited to):
    a. The prophylactic extraction of third molars.
5. For prescription and non-prescription drugs, vitamins, or dietary supplements.
6. For house or hospital calls for dental services and for hospitalization costs (facility-use fees).
7. Incomplete treatment. For example (but not limited to):
    a. Covered person does not return to complete treatment.
    b. Temporary services (for example, but not limited to, temporary restorations).
8. Procedures that are:
    a. Part of a service but are reported as separate services or;
    b. Reported in a treatment sequence that is not appropriate or;
    c. Misreported or;
    d. Represents a procedure other than the one reported.
9. Specialized procedures and techniques. For example (but not limited to):
    a. Precision attachments
    b. Copings and intentional root canal treatment
10. Which are cosmetic in nature as determined by Blue Cross. For example (but not limited to):
    a. Bleaching
    b. Veneer facings
    c. Personalization or characterization of crowns
    d. Bridges and/or dentures
11. Treatment, services, or supplies that are not dentally necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of Blue Cross will apply.
12. Fees for failure to keep scheduled visits.
13. Charges for furnishing medical and dental records or reports and associated delivery charges.
14. Services that are prohibited by law or regulation.
15. Services which are not within the scope of licensure or certification of a provider.
16. Treatment, services, or supplies that are provided at no charge.

Miscellaneous Exclusions

1. Services and or procedures started prior to the covered person's effective date or after the termination date of coverage under this benefit booklet. For example (but not limited to):
    a. Multi-visit procedures such as endodontics
    b. Crowns
    c. Bridges
    d. Inlays
    e. Onlays
    f. Dentures
2. Any claims submitted to Blue Cross by the covered person or on behalf of the covered person in excess of 12 months after the date of service.
3. Services that are provided for the treatment of an employment related injury for which you are entitled to make a worker's compensation claim unless the worker's compensation carrier has disputed the claim.
4. Charges that are eligible, paid, or payable under any medical payment automobile personal injury protection that is payable without regard to fault, including charges for services that are applied toward any deductible, copay, or coinsurance requirement of such a policy.
5. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

Choice of Provider

You may choose any licensed dental care provider for services.

However, choosing a participating provider, may limit out-of-pocket expenses. Participating providers limit their fees to their contracted maximum allowable charges for covered services.

Also, if agreed by the provider, participating providers limit their charges for all services delivered to you and/or your dependent(s), even if the service is not covered for any reason and a benefit is not paid under this benefit booklet.

Participating providers also complete and send claims for covered services directly to us for processing.

To find a participating provider, visit our website at www.bluecrossmnonline.com or call the toll-free number on your member ID Card.

When using a nonparticipating provider, you may have to pay the provider at the time of service, complete and submit your own claims, and/or wait for us to reimburse you. You will be responsible for the provider's full charge which may exceed our maximum allowable charge or usual, customary, and reasonable allowance, resulting in higher out-of-pocket expenses.

Payment of Benefits

This is a general summary of our dental care provider payment methodologies only. Although efforts are made to keep this information as up to date as possible, payment methodologies may change from time to time, and every current provider payment methodology may not be reflected in this summary. Please note that some of these payment methodologies may not apply to your benefit booklet.

We are not liable to pay benefits for any services started prior to a covered person's effective date of coverage. Procedures started prior to your and/or your dependent(s)'s effective date are the liability of you and/or your dependent(s).

Multi-visit procedures are considered "started" when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken.

Participating Provider

When treatments are performed by a participating provider, we will pay covered benefits directly to the participating provider. Both you and the provider will be notified of benefits covered, our payment and any out-of-pocket expenses.

Payment will be based on the maximum allowable charge the treating participating provider has contracted to accept. Maximum allowable charges may vary depending on the geographical area of the participating provider office and the contract between us and the particular participating provider rendering the service.

Participating providers agree by contract to accept maximum allowable charges as payment in full for covered services rendered to you and/or your dependent(s).

Nonparticipating Provider

When treatments are performed by a nonparticipating provider, benefits are substantially reduced, and you will likely incur significantly higher out-of-pocket expenses.

We will either send payment for covered services to you or we may choose to pay the nonparticipating provider. You will still be notified of the services covered, our payment, and any out-of-pocket expenses.

When we pay the nonparticipating provider, we have met our obligation under the benefit booklet. You may not assign your right, if any, to commence legal proceedings against Blue Cross.

Our payment will be based upon the maximum allowable charge or the usual, customary, and reasonable allowance for a covered service. You will be responsible to pay the nonparticipating provider any difference between our payment and the nonparticipating provider's full charge for the services. Nonparticipating providers are not obligated to limit their fees to our maximum allowable charges or the usual, customary, and reasonable allowance.

Who is Eligible for Coverage

This benefit booklet covers only those group members who work in the United States (U.S.) or its Territories.

Group members who work and reside in foreign countries are not eligible for coverage. Employees who are U.S. citizens or permanent residents of the U.S. working outside of the U.S. on a temporary basis are eligible.

Eligible Dependents

If you, your spouse, and/or dependent(s) are group members of the group contractholder, you may be covered as either an employee or as a dependent, but not as both. Your eligible dependent children may be covered under either parent's coverage, but not both.

Your Spouse

Your spouse is:

1. The person to whom you are legally married.
2. Your partner through a civil union in a jurisdiction that recognizes civil unions
3. Your domestic partner. A domestic partner is an adult whom you are in a committed and mutually exclusive relationship with and with whom you are jointly responsible for each other's welfare and financial obligations. Your partner must:
    a. Be at least 18 years of age and unmarried,
    b. Be mentally competent,
    c. Not be your blood relative, and
    d. Reside with you in the same principal residence and intends to do so permanently.

Your Dependent Children

Dependent Children up to the limiting age.

1. Your children.
2. Your stepchildren.
3. Children of your domestic partner.
4. Children legally placed for adoption.
5. Children for whom you or your spouse have been appointed legal guardian.
6. Foster children.
7. Grandchildren who live with you or your spouse continuously from birth and are financially dependent upon you or your spouse.
8. Children awarded coverage because of a court order.
9. A disabled dependent over the limiting age who is not able to support themselves because of developmental disability, mental illness or disorder, or physically disabled and primarily dependent upon the group member for support and maintenance. See section "Adding Disabled Dependents."

Enrollment and Effective Dates

This section outlines the time periods for enrollment and the date coverage starts.

Coverage starts on the date specified in the lower right-hand corner of the front cover. This is the effective date for you and any eligible dependents who enroll before that date.

Monthly premiums must be paid from the date coverage starts. You must check with your group contractholder to determine if you are responsible for all or a portion of these premiums.

Enrollment Periods

If you and any eligible dependents are enrolling after the original effective date of the group contract, the coverage will take effect as follows:

New Group Member Enrollment

You become eligible once you have satisfied the eligibility and probationary requirements as determined by the group contractholder.

Annual Open Enrollment Period

Annual enrollment effective date as agreed upon by the group contractholder and us.

Adding a Newborn or Adopted Child

If a child is born or adopted after the employee's original effective date, such child may be added anytime between birth (or date of adoption) and 30 days after the child's 3rd birthday.

If the child is not added within 30 days after the child's 3rd birthday, the child may be added only if there is a Special Enrollment Period or at the next open Enrollment Period, if any.

Adding a Disabled Dependent

Once the covered child dependent reaches the limiting age, you may apply to continue coverage for the dependent as a disabled dependent.

To be eligible for coverage, the child must meet the disabled dependent criteria in the "Eligible Dependents" section above and be enrolled in your plan prior to reaching the limiting age. We require proof of eligibility, and we may request proof of eligibility again two (2) years later and each year thereafter.

Your request must be received within 31 days from when the child reaches the limiting age.

Special Enrollment Period

If you or any eligible dependents enroll after the initial enrollment or enrollment period, the date of coverage is determined based on the special enrollment process.

Special enrollment periods are when you or your eligible dependent(s) may enroll in the dental plan under certain circumstances after becoming eligible for coverage when all enrollment conditions are met. Unless otherwise specified, coverage will be made effective in accordance with applicable regulatory requirements.

Eligible Circumstances	The Group Member or Dependent	Request for coverage is received no later than	Effective date of coverage is
New Dependent	can request coverage for the dependent because of: a. marriage, b. birth, c. adoption, or placement for adoption or foster care, or d. court order	30 days after the event Refer to section “Adding a Newborn or Adopted Child”	the date of: a. marriage, b. birth, c. adoption or placement for adoption or foster care, or d. court order
Loss of other group dental plan coverage	a. waived this dental coverage because they were covered under another group dental plan and b. is no longer covered under the other dental plan because: i. COBRA continuation has been exhausted (not due to failure to pay premium or for cause), ii. termination of employment, reduction in hours iii. death of the Employee, iv. he/she is no longer eligible for the plan due to a divorce or legal separation, v. loss of dependent status, vi. all employer contributions towards the coverage were terminated, or vii. the individual no longer lives or works in the service area	30 days after the termination of coverage or employer contribution	the day after the termination of prior coverage

Eligible Circumstances	The Group Member or Dependent	Request for coverage is received no later than	Effective date of coverage is
Loss of Medical Assistance (Medicaid) or Children's Health Insurance Program (CHIP) Coverage	a. waived this dental coverage because they were covered under Medicaid or CHIP and b. they must have been covered under Medicaid or CHIP at the time coverage was previously offered to the group member or dependent	60 days after the termination of Medicaid or CHIP coverage	a. 1st of the following month if your application is received between the 1st and the 15th of the month b. Otherwise, the effective date will be the 1st of the following second month
Eligibility for Premium Assistance through Medicaid or CHIP	must have documentation that they are eligible for premium assistance through Medicaid or CHIP from their employer	60 days after becoming eligible for premium assistance through Medicaid or CHIP	a. 1st of the following month if your application is received between the 1st and the 15th of the month b. Otherwise, the effective date will be the 1st of the following second month

Termination of This Plan

During the course of your coverage or a continuation period, if your marital status changes or a dependent ceases to be a dependent eligible for coverage under the terms of the group contract, you or your dependent must notify the plan administrator in writing. In addition, you must notify the plan administrator if a disabled group member or family member is no longer disabled.

You must provide notification to your group contractholder within 60 days of changes in you or your dependent's eligibility to obtain your continuation of coverage options. Refer to the "Continuation of Coverage" section for information regarding extension of coverage, or how to obtain an individual qualified plan.

If you or your dependents do not provide this required notice, any dependent who loses coverage is NOT eligible to elect continuation coverage. Furthermore, if you or your dependents do not provide this required notice, you or your dependent must reimburse any claims mistakenly paid for expenses incurred after the date coverage actually terminates.

Termination Reasons and Termination Dates:

Event	What does this mean?	Who this applies to	Coverage Ends on the last day of the month that
Terminated for all group members	a. You will receive a 30-day notice of termination prior to the effective date of cancellation b. The notice will be sent using a list of addresses that is updated every 12 months c. You will not receive a notice if we have reasonable evidence that this coverage will be replaced by a similar policy, plan, or contract	Group member and dependent(s)	As stated in the notice
Required premiums are not paid	a. Your employer must provide full payment of all premiums to us b. You must pay all premiums for continuation coverage	Group member and dependent(s)	Premiums are due
Group member is no longer eligible	Your employer determines eligibility	Group member and dependent(s)	Eligibility ends
Entering military service	Applies to duty lasting more than 31 days	Group member and dependent(s)	Military service begins
Dependent is no longer eligible	Eligibility as defined in “Eligible Dependents” section	Dependent(s) for which event applies	The event occurred
Group member terminates coverage	You request that coverage be terminated	Group member and dependent(s)	The termination request is received
Determination of fraud or misrepresentation	We determine that you have committed fraud or misrepresentation regarding eligibility or any other material fact	Group member and dependent(s)	Date we determine fraud or misrepresentation committed

Benefits After Coverage Terminates

We are not liable to pay any benefits for covered services that are started after you or your dependent(s) have been terminated.

However, coverage for completion of a dental procedure requiring two (2) or more visits on separate days will be extended for a period of 90 days after the termination date to allow for the procedure to be finished. The procedure must be started prior to the termination date.

The procedure is considered “started” when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. This extension does not apply if the group contract terminates for failure to pay premium.

Termination for Fraudulent Practices

Coverage for you and/or your dependent(s) will be terminated if you and/or your dependent(s) engage in fraud of any type or intentional misrepresentation of material fact including, but not limited to:

1. Submitting fraudulent misstatements or omissions about your dental history or eligibility status on the enrollment form for coverage,
2. Submitting fraudulent, altered, or duplicate billings for personal gain, or
3. Allowing another party not eligible for coverage under the benefit booklet to use your and/or your dependent's coverage.

Continuation of Coverage

Type of Coverage

Generally, continuation coverage is the same coverage that you or your dependent had on the day before the qualifying event. You have the same rights under this plan as active employees or their dependents as noted under "Annual Open Enrollment" and "Special Enrollment."

Qualifying Events

You or your covered dependents may continue this coverage if it ends because of one of the qualifying events listed below. You and your eligible dependents must be covered on the day before the qualifying event in order to continue coverage.

NOTE: You may have a right to Special Enrollment in a new plan such as an individual dental plan or another employer plan.

Qualifying Event	What does this mean?	Who May Continue	Maximum Continuation Period is earlier or earliest of
Termination of employment	Voluntary or involuntary termination for reasons other than gross misconduct	Group member and dependent(s)	a. 18 months from the 1st of month following the event, or b. Enrollment date in other group coverage
Reduction in the hours	Due to lay-off, leave of absence, strike, lockout, change from full-time to part-time employment		
Total disability of group member	a. You are not able to engage in or perform the duties of the for your regular occupation or employment within the first two (2) years of disability b. After the first two (2) years, you are not able to perform any occupation for which you are educated or trained	Group member and dependent(s)	a. Date total disability ends, or b. Date coverage would otherwise end
Death of the group member		Dependent(s)	a. Enrollment date in other group coverage, or b. Date coverage would otherwise end if the group member had lived
Group member becomes enrolled in Medicare		Dependent(s)	a. 36 months from date of event, or b. Enrollment date in other group coverage, or c. Date coverage would otherwise end

Qualifying Event	What does this mean?	Who May Continue	Maximum Continuation Period is earlier or earliest of
Divorce or legal separation	a. Spouse/ex-spouse was covered on the day before the entry of the valid decree of dissolution of marriage b. If coverage for Spouse was terminated in anticipation of the divorce or legal separation, a later divorce or legal separation is considered a qualifying event	Spouse/ex-spouse and any dependent children who lose coverage	a. Enrollment date in other group coverage, or b. Date coverage would otherwise end
Dependent Child is no longer eligible	Eligibility as defined in "Eligible Dependents" section	Dependent Child	a. 36 months from date of event, or b. Enrollment date in other group coverage, or c. Date coverage would otherwise end
Group contractholder filing Chapter 11 bankruptcy	a. You are a retiree of the group contractholder filing Chapter 11 bankruptcy b. includes substantial reduction in coverage within one (1) year of filing	Retiree	Lifetime continuation
		Dependent(s)	Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death
		Surviving Spouse	a. Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death b. Lifetime continuation when retiree is deceased at time of event and spouse is already covered by the group contract

Qualifying Event Extensions

Maximum coverage periods of 18 or 36 months can be extended in certain circumstances.

Total Disability of Dependent(s)

1. You have continuation coverage because group member was terminated from employment or had a reduction of hours, and
2. the disability occurs prior to the end of the initial 18-month continuation period, and
3. Social Security Administration (SSA) determines a dependent covered under the initial continuation coverage is disabled at any time during the first 60 days of continuation.

Dependents covered under the initial continuation coverage may extend coverage for a maximum period of 29 months from the date the group member leaves employment or until the date total disability ends or the date coverage would otherwise end, whenever comes first.

Second Qualifying Event

1. You have continuation coverage because group member was terminated from employment or had a reduction of hours, and
2. the second qualifying event occurs prior to end of the 18-month continuation period or 29-month disability extension, and
3. the second qualifying event has at least a 36-month continuation period.

Dependents covered under the initial continuation coverage may extend coverage for a maximum period of 36 months from date of the initial event or the enrollment date in other group coverage or the date coverage would otherwise end, whichever comes first.

Certain qualifying events allow lifetime continuation, refer to the Qualifying Event table above.

Group Member Enrolled in Medicare

1. Group member is enrolled in Medicare, and
2. later experiences termination of employment or a reduction in the hours worked, and
3. this occurs within 18 months after the date of the group member's Medicare enrollment.

Dependents may extend coverage for a maximum period of 36 months from date of event or the enrollment date in other group coverage or the date coverage would otherwise end, whichever comes first.

If the qualifying event is more than 18 months after Medicare enrollment, is the same day as the Medicare enrollment, or occurs before Medicare enrollment, no extension is available.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

This continuation right runs concurrently with your continuation right under COBRA when you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, not a state, call-up), the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States.

Group member and dependents may extend coverage for a maximum period of 24 months.

Continuation Notice Obligations

You or your dependents each are entitled to an independent right to elect continuation coverage. Therefore, a spouse/ex-spouse may not decline coverage for the other spouse/ex-spouse and a parent cannot decline coverage for a non-minor dependent child who is eligible to continue coverage.

In addition, a dependent may elect continuation coverage even if the covered group member does not elect continuation coverage.

If you or your dependent's address changes, you *must* notify the plan administrator in writing so the plan administrator may mail you or your dependent important continuation notices and other information.

You and your dependents may elect continuation coverage even if covered under another employer-sponsored group dental plan or enrolled in Medicare.

Contact the group contractholder to determine how to elect continuation coverage.

Notices for	Group Member /Dependent	Group Contractholder	Eligible Group Member / Dependent
Contract Termination due to a. Termination of employment b. Reduction in the hours c. Death of the group member d. Group member becomes enrolled in Medicare	Notice must be provided to group contractholder within 60 days of the event if group contractholder is not aware of the event	Send the qualifying event notice to eligible individuals within 14 days of the event or upon receipt of notice to advise a. of the right to elect continuation coverage or b. when continuation is not available and why	Elect continuation coverage within 60 days of a. the qualifying event or b. the date of the qualifying-event notice, whichever is later
Contract Termination due to a. Divorce or legal separation b. Dependent Child is no longer eligible	a. Notice must be provided to group contractholder within 60 days of the event b. Notice must be provided to group contractholder within 60 days after a later divorce or legal separation when coverage was earlier terminated in anticipation of the divorce or legal separation	Upon receipt of notice, notify the eligible individuals a. of the right to elect continuation coverage or b. when continuation is not available and why	Elect continuation within 60 days a. of the qualifying event, or b. the date of the qualifying event notice, whichever is later
Extension of continuation due to a. Disability determination or b. New qualifying event	Notice must be provided a. to group contractholder within 60 days of the disability determination or new event and b. before the end of the initial 18-month or 29-month continuation period	Upon receipt of notice a. notify the eligible individuals of the right to elect continuation coverage, or b. notify you when an extension is not available and why	Elect continuation within 60 days a. of the qualifying event, or b. the date of the qualifying event notice, whichever is later

Termination of Continuation Coverage Before the End of Maximum Coverage Period

Continuation coverage of the group member and dependents will automatically terminate when any one of the following events occur:

1. The group contractholder no longer provides group dental coverage to any of its employees.
2. The premium for continuation coverage is not paid when due.
3. If during an 18-month or 29-month maximum coverage period due to disability the SSA makes the final determination that the qualified beneficiary is no longer disabled. You must notify the group contractholder within 30 days of the final determination.
4. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to any covered group members or their dependents whether or not they are on continuation coverage.
5. Voluntarily canceling your continuation coverage.

When termination takes effect earlier than the end of the maximum period of continuation coverage, a notice will be sent from the plan administrator. The notice will contain the reason continuation coverage has been terminated, the date of the termination, and any rights to elect alternative coverage that may be available.

Continuation Premiums

Premiums for continuation can be up to the group rate plus a two (2) percent administration fee.

In the event of a dependent's disability, the premiums for continuation for the group member and dependents can be up to 150% of the group rate for months 19-29 if the disabled dependent is covered.

If the qualifying event for continuation is the group member's total disability, the administration fee is not permitted.

All premiums are paid directly to the group contractholder.

Coordination of Benefits

If you or your dependent(s) are covered by any other dental plan and receive a service covered by this plan and the other dental plan, benefits will be coordinated. This means that one plan will be primary and determine its benefits before those of the other plan, and without considering the other plan's benefits. The other plan will be secondary and determine its benefits after the primary plan.

The secondary plan's benefits may be reduced because of the primary plan's payment. Each plan will provide only that portion of its benefit that is required to cover expenses. This prevents duplicate payments and overpayments. Upon determination of primary or secondary liability, this plan will determine payment.

Coordination of Benefits Definition

When used in this Coordination of Benefits (COB) section, the following words and phrases have the definitions below.

Other Dental Plan - Any form of coverage that is separate from this plan with which coordination is allowed.

Other dental plan will be any of the following that provides dental benefits, or services, for the following:

1. Group insurance or group type coverage, whether insured or uninsured, and
2. Coverage other than school accident type coverage (including grammar, high school, and college student coverages) for accidents only, including athletic injury, either on a 24-hour basis or on a "to and from school basis," or group type hospital indemnity benefits of $100 per day or less.

Primary Plan - The plan that determines its benefits first and without considering the other plan's benefits.

A plan that does not include a COB provision may not take the benefits of another plan into account when it determines its benefits.

Secondary Plan - The plan that determines its benefits after those of the other plan (primary plan).

Benefits may be reduced because of the other plan's (primary plan) benefits.

Plan - This document including all schedules and all riders thereto, providing dental care benefits to which this COB provision applies, and which may be reduced as a result of the benefits of other dental plans.

COB Determination Rules

The fair value of services provided by Blue Cross will be considered to be the amount of benefits paid by us. We will be fully discharged from liability to the extent of such payment under this provision.

NOTE: The plan covering an individual as a COBRA continuee will be secondary to a plan covering that individual as a member or a dependent.

If none of the following rules apply, then the contract that has continuously covered the member for a longer period of time will be primary.

In order to determine which plan is primary, this plan will use the following rules.

COB for You and Your Dependent(s)

1. If the other plan does not have a provision similar to this one, then that plan will be primary.
2. If both plans have COB provisions, the plan covering the member as a primary insured is determined before those of the plan that covers the person as a dependent.

COB for Your Dependent Children

1. Birthday Rule

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.
b. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
c. If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent, and if as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.

2. Dependent child and parents are separated or divorce

a. The plan of the parent with custody of the child will be first.
b. Then plan of the spouse of the parent with the custody of the child.
c. Then the plan of the parent not having custody of the child.
d. If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses 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 will be secondary.
e. If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child will follow the birthday rule.

COB for Active/Inactive Member

1. For actively employed members and their spouses over the age of 65 who are covered by Medicare, the plan be primary.
2. When one plan is a retirement plan and the other is an active plan, the active plan is primary.
3. When two retirement plans are involved, the one in effect for the longest time is primary.
4. If another plan does not have this rule, then this rule will be ignored.

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide that facts are needed. We may get needed facts from, or give them to, any other organization or person. We do not need to tell, or get the consent of, any person to do this unless applicable federal or state law prevents disclosure of information without the consent of the covered person or covered person's representative. Each person claiming benefits under this plan must give any facts needed to pay the claim.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan, and we will not 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 services prepaid by us.

Right of Recovery

If we pay more than we should have paid under these COB provisions, we may recover the excess from one or more of the following:

1. Persons we have paid or for whom we have paid
2. Insurance companies
3. Other organizations.

The amount paid includes the reasonable cash value of any benefits provided in the form of services. You are required to assist us to implement this section.

Reimbursement and Subrogation

If we pay benefits for expenses you incur as a result of any act of any person, and you later obtain full compensation, you are obligated to reimburse us for the benefits paid.

If you or your dependents receive benefits under this plan arising out of an illness or injury for which a responsible party is or may be liable, we are also entitled to subrogate against any person, corporation, and/or other legal entity, or any insurance coverage, including both first- and third-party automobile coverages to the extent we provided any benefits.

Our right to reimbursement and subrogation is subject to you obtaining full recovery, as explained in Minnesota statutes 62A.095 and 62A.096. Unless we are separately represented by our own attorney, our right to reimbursement and subrogation is subject to reduction for first, our pro rata share of costs, disbursements, and then reduced by reasonable attorney fees incurred in obtaining the recovery. For the purposes of this section, full recovery does not include payments made by a dental plan to, or for the benefit of, a covered person.

If Blue Cross is separately represented by an attorney, Blue Cross and the covered member, by their attorneys, may enter into an agreement regarding allocation of the covered member's costs, disbursements, and reasonable attorney fees and other expenses.

If Blue Cross and the covered member cannot reach agreement on allocation, Blue Cross and the covered member shall submit the matter to binding arbitration.

Notice Requirement

You must provide timely written notice to us of the pending or potential claim if you make a claim against a third party for damages that include repayment for expenses incurred for your benefit.

We may take appropriate action to preserve our rights under this Reimbursement and Subrogation section, including our right to intervene in any lawsuit you have commenced.

Duty to Cooperate

You must cooperate with Blue Cross in assisting it to protect its legal rights under this provision.

You agree that the limited period in which we may seek reimbursement or to subrogate does not commence to run until you or your attorney has given notice to us of your claim against a third party.

Release of Records

You agree to allow all health care and dental providers to give us needed information about the care they provide to you.

We may need this information to process:

1. Claims
2. Conduct Utilization Review
3. Conduct care management and quality improvement activities
4. Reimbursement and subrogation review
5. Other dental plan activities as permitted by law

We keep this information confidential, but we may release it if you authorize release, or if state or federal law permits or requires release without your authorization.

If a provider requires special authorization for release of records, you agree to provide this authorization. Your failure to provide authorization or requested information may result in denial of your claim.

Claims Process

Notice of Claim

Written notice of claim must be given to Blue Cross within 20 days after the occurrence or commencement of any loss covered by the benefit booklet, or as soon thereafter as is reasonably possible.

Notice given by or on behalf of you or your covered dependent(s) to Blue Cross, with information sufficient to identify the person making the claim, shall be deemed notice to Blue Cross.

Claim Forms

Upon receipt of a notice of claim, we will furnish to you such forms as are usually furnished by us for filing proof of loss.

If such forms are not furnished before the expiration of 15 days after we received notice of any claim under the benefit booklet, the person making such claim shall be deemed to have complied with the requirements of the benefit booklet as to proof of loss upon submitting within the time fixed in the benefit booklet for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be furnished to us at our office within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

Our acknowledgment of the receipt of notice given or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of Blue Cross in defense of any claim arising under such benefit booklet.

Time Payment of Claims

All benefits payable under this benefit booklet for any loss will be paid immediately after receipt of due written proof of such loss.

Payment of Claims

All benefits under this benefit booklet shall be payable to your participating provider, you, or your dependent. When the dependent is a minor or otherwise not competent to give a valid release, such benefits may be made payable to the custodial parent, guardian, or other person actually providing support.

At the option of Blue Cross and unless you request otherwise in writing not later than the time of filing proofs of such loss, all or a portion of any indemnities provided by this benefit booklet on account of dental services may, be paid directly to the participating dental office rendering such services.

Blue Cross does not pay claims to providers or to members for services received in countries that are sanctioned by the United States Department of Treasury's Office of Foreign Assets Control (OFAC). Countries currently sanctioned by OFAC include Cuba, Iran, and Syria. OFAC may add or remove countries from time to time.

Right of Examination

We have the right to ask you to be examined by a dental care provider during the review of any claim. We choose the dental care provider and pay for the exam whenever we request this.

We also have the right to make an autopsy in case of death where it is not forbidden by law. Failure to comply with this request may result in denial of your claim.

Review of a Benefit Determination

If you are not satisfied with a benefit determination or payment, please contact our customer service department at the toll-free telephone number listed in the “Questions?” section or on the back of your member ID. We will try to resolve your oral complaint as quickly as possible.

However, if after speaking with a customer service representative, our resolution of your oral complaint is wholly or partially adverse to you or not resolved to your satisfaction, within ten (10) days of our receipt of your oral complaint, you may submit an appeal in writing.

We will provide you a complaint form on which you can include all the necessary information to file your appeal. If you need assistance, we will complete the written complaint form and mail it to you for your signature.

You must tell us all reasons and arguments in support of your appeal, and you must identify and provide all evidence in support of your appeal unless that evidence is already in our possession. Refer to the “Appeal Process” below. Contact us for further steps you can take regarding your claim.

Appeal Process

Appeal Procedures Definitions

The following definitions apply to the appeal procedures:

Adverse Benefit Determination - A decision relating to a dental care service or claim that is partially or wholly adverse to the complainant.

Appeal - Any grievance that is not the subject of litigation concerning any aspect of the provision of services under your group contract. If the appeal is from an applicant, the appeal must relate to the application. If the appeal is from a formerly covered person, the appeal must relate to the provision of dental services during the period of time the covered person was enrolled in the Plan.

Appeal Procedures

If we decide a claim that is wholly or partially adverse to you, and you wish to appeal, you are required to submit an appeal. You have 180 days from the date you received notice of the Adverse Benefit Determination to appeal the decision. You can call or write us with your appeal. You or anyone you authorize to act on your behalf may submit your appeal in writing, or you may request a complaint form. We will send a complaint form to you upon request. If you need assistance, we will complete the written complaint form and mail it to you for your signature.

The request for an appeal should include:

1. The covered person's name, identification number, and group number
2. The dental claim for which coverage was denied
3. A copy of the denial
4. The reason why you or your dental care provider believes the service should be covered
5. Any available dental information you believe will be helpful to the decision.
6. Your appeal must state all reasons and arguments in support of the appeal, and you must submit all evidence in support of your appeal, unless that evidence is already in our possession.

Send your Appeal to:

Dental Customer Service
Appeals Unit
P.O. Box 69420
Harrisburg, PA 17106-9420

In addition, you may file your appeal with the Minnesota Commissioner of Commerce at any time by calling (651) 539-1600 or toll-free 1-800-657-3602.

When a dentally necessary determination is necessary to resolve your appeal, we will process your appeal using utilization review appeal procedures. Utilization Review applies a well-defined process to determine whether dental care services are dentally necessary and eligible for coverage. The decision on this appeal will be made by a dental care professional who did not make the initial determination. Utilization Review applies only when the service requested is otherwise covered under this dental plan. In order to conduct utilization review, we will need specific information. If you or your attending dental care professional do not release necessary information, approval of the requested service, procedure, or admission to a facility may be denied.

We will notify you that we have received your written appeal. We will inform you of our decision and the reasons for the decision within 30 days of receiving your appeal and all necessary information. If we are unable to make a decision within 30 days due to circumstances outside our control, we may take up to 14 additional days to make a decision. If we take more than 30 days to make a decision, we will inform you of the reasons for the extension. If we need specific information, including medical or dental records, to complete our review and you or your health/dental care professional does not release the requested information. Your claim may be denied. You have the right to review the information that we relied on in the course of the appeal.

The appeals and determination processes described above are subject to change if required or permitted by changes in state or federal law governing appeal procedures

General Information

Entire Contract

This benefit booklet and the group contract issued to the group contractholder make up the entire contract of coverage. The master group contract is available for your inspection at your group contractholder's office. Your group contractholder is the Plan Administrator for your coverage plan.

We have discretionary authority to determine your eligibility for benefits and to construe the provisions of the group contract and this benefit booklet. All statements made by the creditor, employer, trustee, or any executive officer or trustee on behalf of the group to be insured, shall, in the absence of fraud, be deemed representations and not warranties, and that no such statement shall be used in defense to a claim under the contract, unless it is contained in the written enrollment form.

This benefit booklet is issued and delivered in the state of Minnesota. It is subject to the substantive laws of the state of Minnesota, without regard to its choice of law principles; and, it is not subject to the substantive laws of any other state.

This benefit booklet describes your Blue Cross dental coverage. It replaces all other dental benefit booklets you have received from us. This benefit booklet explains the eligibility, covered services, and terms of coverage. It is important that you read this entire benefit booklet carefully. If you have questions about your coverage, please contact us at the address or telephone numbers listed on the "Questions?" page.

Blue Cross is the insurer. This benefit booklet is a fully insured dental benefit booklet designed solely to provide dental care. Coverage is subject to all terms and conditions of this benefit booklet, including dental necessity.

All changes to the benefit booklet must be approved by us. No agent may change this benefit booklet or waive any of its provisions.

Changes to the Contract

The group contractholder reserves the power at any time and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the code or ERISA) to modify or amend, in whole or in part, any or all provisions of the dental care plan, provided, however that no modification or amendment shall divest an employee of a right to those benefits to which he or she has become entitled under the dental plan.

The group contractholder may add/change eligible classes of employees from time to time, and such changes will be noted in the group contract.

Any amendment to this dental plan may be effected by a written resolution adopted by the Plan Administrator. Blue Cross will communicate any adopted changes to the group contractholder not later than 60 days before the date on which the adopted changes will become effective.

All changes to the group contract must be approved in writing by one (1) of our executive officers and attached to the group contract with the group contractholder. No agent can legally change the group contract or waive any of its terms

Time Limit for Misstatements

If there is any misstatement in the written enrollment form that the group contractholder completes, we cannot use the misstatement to cancel coverage that has been in effect for, or deny a claim incurred on a date that is on or after, two (2) years or more from the initial date of coverage issued as a result of that enrollment form. This time limit does not apply to fraudulent misstatements.

Indemnity for Loss of Life

In the event of loss of life, if you used a nonparticipating provider, we will pay for covered services in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to your estate. Any other outstanding payments for covered services unpaid at the time of your death may, at your option, be paid either to such beneficiary or to such estate. All other payments for covered services will be payable to you.

Change of Beneficiary

Unless you make an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to you. The consent of the beneficiary is not required to surrender or assign benefits under this benefit booklet or to change the beneficiary or make other changes in this benefit booklet.

Assignment

Blue Cross may assign this contract and its rights and obligations hereunder.

Conformity with State Laws

Any part of the contract in conflict with the laws of the state where the group member lives on the contract's effective date is changed to conform to the minimum requirements of that state's law.

After the effective date, the contract may be amended without mutual agreement of the parties. Such amendment will not affect a claim incurred prior to the effective date of the change.

Legal Actions

No action at law or in equity shall be brought to recover on the benefit booklet prior to the expiration of 60 days after written proof of loss has been filed in accordance with the requirements of the benefit booklet.

No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

No Third-Party Beneficiaries

The benefits described in this plan are intended solely for the benefit of you and your covered dependents.

No one else may claim to be an intended or third-party beneficiary of this plan.

No one other than you or your dependents may bring a lawsuit, claim or any other cause of action related in any way to this plan, and you may not assign such rights to any other person.

Third-Party Payments of Premium and/or Cost-Sharing

As required by law, Blue Cross will accept premium and cost-sharing payments made on behalf of enrollees by the following persons/entities:

1. the Ryan White HIV/AIDS Program;
2. other Federal and State government programs (or grantees) that provide premium and cost-sharing support for specific individuals; and
3. Native nations, tribal organizations, and Urban Indian Organizations.
4. Employers using a Health Reimbursement Arrangement (HRA) are permitted, to the extent such payments are lawfully funded through an HRA that constitutes a group health plan under applicable regulations, which have not been enjoined by a court of competent jurisdiction. This is known as an Individual Coverage Health Reimbursement Arrangement (ICHRA).

Blue Cross may, in its sole discretion and in accordance with applicable law and regulatory guidance, decline to accept premium and cost-sharing payments made directly or indirectly* by any other person or entity from which Blue Cross is not required by law to accept third-party premium and/or cost-sharing payments.

"Payments" include those made by any means, for example:

1. Cash
2. Check
3. Money order
4. Credit card payment
5. Electronic fund transfer, etc.

Third parties not listed above (or from whom Blue Cross is not required by law to accept third-party payment) are referred to as "ineligible third parties."

For purposes of clarity, but not limitation, commercial (or for-profit) entities, hospitals, and other health care providers (including, without limitation, suppliers) are ineligible third parties. Religious institutions and other not-for-profit organizations may also be considered ineligible third parties.

Any cost-sharing paid by ineligible third parties will not be counted toward an enrollee's deductible or out-of-pocket maximum. "Cost-sharing" includes payments such as deductibles, copays and coinsurance. Blue Cross may make retroactive adjustments to account for any payments made by ineligible third parties.

You are required to immediately notify Blue Cross of any change in your (or your dependent(s)) information submitted in connection with the application for coverage or otherwise provided with respect to any third-party payment.

Any person or entity that violates these restrictions and/or makes any ineligible third party payment described above will be held responsible for and will be required to reimburse Blue Cross for all costs associated with the relevant plan or policy related to the violation or ineligible payment.

Blue Cross maintains sole discretion with respect to its acceptance of third-party payments. Blue Cross may make changes to its administration of same at any time and as otherwise needed to support compliance with law and/or applicable regulatory guidance.

If you have questions about this third-party payment policy or whether Blue Cross will accept premium and/or cost-sharing payments made by a specific person or entity, please contact Customer Service at the number located on the back of your member ID Card.

*Indirect payments include, for example, an ineligible third-party making a check out to or otherwise paying the enrollee to permit the enrollee to pay amounts due to Blue Cross.

Premium Payment

We charge your employer a monthly rate (premium). We may revise this rate during the plan year due to changes in the group's status.

Your monthly contribution amount (if any) is determined by your employer.

Time Periods

When the time of day is important for benefits or determining when coverage starts and ends, a day begins at 12:00 a.m. United States Central Time and ends at 12:00 a.m. United States Central Time the following day.

Terms You Should Know

Benefit Booklet - This document, including schedules, addenda and/or endorsements, if any, which are attached to the benefit booklet and describe the dental coverage purchased from Blue Cross.

Blue Cross - BCBSM, Inc. dba Blue Cross and Blue Shield of Minnesota shown on the front page of this benefit booklet, its affiliate or a third party with which Blue Cross contracts for a provider network and/or to perform certain functions to administer the terms of this benefit booklet. Also referred to as "we," "our," or "us."

Calendar Year – The period starting on January 1st of each year and ending at midnight December 31st of that year.

Contract Year - The period of 12 months beginning on the effective date or the anniversary of the effective date of the group member's benefit booklet and ending on the day before the renewal date.

Coinsurance - The remaining percentages or dollar amounts of the maximum allowable charge or the usual, customary and reasonable allowance for a covered service that are the responsibility of you and/or your dependent(s) after Blue Cross pays the percentages or dollar amounts shown on the "Schedule of Benefits."

Covered Service(s) - Services shown on the "Schedule of Benefits" for which benefits will be covered subject to the "Schedule of Exclusions."

Deductible(s) - A specified amount of expenses set forth in the "Schedule of Benefits" for covered services that must be paid by you and/or your dependent(s) before Blue Cross will pay any benefit.

Dental Care Provider - A person licensed to practice dentistry in the state in which dental services are provided. Dental care provider will include other duly licensed dental practitioners under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

Dentally Necessary - Dental services that a provider exercising prudent clinical judgement, would provide to a covered person for the purpose of preventing, evaluating, diagnosing or treating dental injury or disease, that are in accordance with generally accepted standards of dental practice clinically appropriate considered effective for the covered person's condition, not provide primarily for the convenience of the covered person or provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results. For these purposes, generally accepted standards of dental practice means standards that are based on credible scientific evidence published in peer-reviewed dental literature generally recognized by the relevant dental community.

Effective Date - The date on which the benefit booklet begins or the date on which coverage for a covered person begins.

Enrollment Period - A period of time agreed upon by the group member and us or our authorized representative during which a member may apply for insurance.

Exclusion(s) - Services, supplies, or charges that are not covered under the benefit booklet as stated in the "Schedule of Exclusions."

Group Member(s) - The employee for whom coverage has been provided by the contractholder.

Limitation(s) - The maximum frequency or age limit applied to a covered service set forth in the "Schedule of Benefits."

Limiting Age - The age for a dependent child defined as when a dependent child reaches age 26 or the age when a dependent child is found to no longer be both incapable of self-sustaining employment by reason of mental or physical disability and chiefly dependent upon the group member for maintenance and support.

Maximum(s) - The greatest amount Blue Cross is obligated to pay for all covered services rendered during a specified period as shown on the "Schedule of Benefits."

Maximum Allowable Charge(s) - The greatest amount the benefit booklet will allow for a specific service.

Nonparticipating Provider(s) - A dental care provider who has not contracted with us to limit his/her charges to you and/or your dependent(s).

Out-of-Pocket Expense(s) - Costs not paid by us, including but not limited to coinsurance, deductibles, amounts billed by nonparticipating dental care providers that are over the maximum allowable charge or the usual, customary and reasonable allowance, costs of services that exceed the benefit booklet limitations or maximums, or for services that are exclusions. The covered person is responsible to pay for out-of-pocket expenses.

Participating Provider(s) - A dental care provider who has executed a participating dental care provider agreement with us, under which he/she agrees to accept maximum allowable charges as payment in full for covered services. Participating dental care providers may also agree to limit their charges for any other services delivered to you and/or your dependent(s).

Premium(s) - Payment that must be remitted in exchange for coverage of you and/or your dependent(s) under the benefit booklet.

Renewal Date - The date the benefit booklet renews.

Schedule of Benefits -The summary of covered services, benefit booklet payments, deductibles, and maximums applicable to benefits payable under the benefit booklet.

Schedule of Exclusions -The list of exclusions applicable to benefits, services, supplies, or charges under the benefit booklet.

Termination Date -The date on which the dental coverage ends for you and/or your dependent(s) or on which the benefit booklet terminates.

Usual, Customary and Reasonable - An allowance equal to or no greater than the dental provider charges for a particular service within a specific area.

Minnesota Life and Health Insurance Guaranty Association Notice

Notice Concerning Policyholder Rights in an Insolvency under Minnesota Life and Health Insurance Guaranty Association Law

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, subject to limits and exclusions, in the event the insurer becomes financially impaired or insolvent. The protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
3300 Wells Fargo Center
90 South 7th Street
Minneapolis, Minnesota 55402
Telephone: (612) 322 8713
Fax: (402) 474 5393
Executive Director: Gerald C. Backhaus

The **maximum amount** the Guaranty Association will pay for all policies on one life by the same insurer **is limited to $500,000. Subject to this $500,000 limit**, the Guaranty Association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 or the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the Association shall not be responsible for more than $10,000,000 in claims for all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the Guaranty Association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Association's limits, you may still recover a part, or all, of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The Guaranty Association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

The coverage provided by the Guaranty Association is not a substitute for using care in selecting insurance companies that are well managed and financially stable. In selecting an insurance company or policy you are advised not to rely on coverage by the Guaranty Association.

This notice is required by Minnesota state law to advise policyholders of life, annuity or health insurance policies of their rights in the event their insurance carrier becomes financially impaired or insolvent. This notice in no way implies that the company currently has any type of financial problems. All life, annuity and health insurance policies are required to provide this notice