Delta Dental of Minnesota

State Dental Plan – Delta Dental

Summary of Benefits

State of Minnesota

Group Number 216

Specific Information About the Plan

Summary of Benefits Effective Date: The later of January 1, 2026 or the covered person's effective date of coverage under the Plan.

Employer:	State of Minnesota
Name of the Plan:	The Plan shall be known as the State Dental Plan – Delta Dental which provides employee and dependent dental benefits.
Address of the Plan:	State of Minnesota Minnesota Management and Budget Employee Insurance 400 Centennial Office Building 658 Cedar Street, St Paul MN 55155
Group Number:	216
Plan Year:	The plan year begins on January 1.
Plan Fiscal Year Ends:	December 31
Plan Sponsor: (is ultimately responsible for the management of the Plan; may employ or contract with persons or firms to perform day-to-day functions such as processing claims and performing other Plan-connected services.)	State of Minnesota Minnesota Management and Budget Employee Insurance
Agent for Service of Legal Process:	Galen Benshoof, Enterprise Director Minnesota Management and Budget Employee Insurance 400 Centennial Office Building 658 Cedar Street St. Paul, MN 55155
Named Fiduciary: (has the authority to control and manage the operation and administration of the Plan; has discretionary authority to determine eligibility for benefits or to construe the terms of the Plan.)	State of Minnesota Minnesota Management and Budget Employee Insurance
Funding:	Claims under the Plan are paid from the assets of a trust of the Employer.
Claims Administrator: (provides administrative services to the Plan Sponsor in connection with the operation of the Plan, such as processing of claims and other functions, as may be delegated to it.)	Delta Dental of Minnesota 500 Washington Avenue South Suite 2060 Minneapolis, MN 55415-1163 612-224-3300 877-268-3384
Network Providers:	State Dental Plan Network National Network available outside of Minnesota

STATE EMPLOYEE GROUP INSURANCE PROGRAM (SEGIP) - HEALTH PLANS

NOTICE OF PRIVACY PRACTICES

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

A. Introduction

The State of Minnesota sponsors the State Employee Group Insurance Program (SEGIP) for its employees. SEGIP contains several health plan components, described below (the Plan). SEGIP is required by federal law to provide You this Notice of the Plan's privacy practices and related legal duties and of Your rights in connection with the use and disclosure of Your protected health information (PHI). Carefully review this Notice to understand your individual rights and the ways that the Plan protects your privacy.

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

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

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

You may have additional rights under state law. State laws that provide greater privacy protection or broader privacy rights will continue to apply, including the Minnesota Government Data Practices Act detailed in Section XIX below.

B. Health Plans covered by this Notice

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

Name of Plan	Plan Administrator	Contracted Administrators
The Minnesota Advantage Health Plan	SEGIP	Blue Cross and Blue Shield of Minnesota, Blue Cross and Blue Shield of Minnesota PPO HealthPartners, HealthPartners PPO Pharmacy benefit claims through CVS Caremark
The Advantage High Deductible Health Plan	SEGIP	Blue Cross and Blue Shield of Minnesota, Blue Cross and Blue Shield of Minnesota PPO HealthPartners, HealthPartners PPO Pharmacy benefit claims through CVS Caremark
HealthPartners Dental Plan	SEGIP	HealthPartners
The State Dental Plan	SEGIP	Delta Dental
Flexible Benefits Accounts	SEGIP	Benefit Resource Inc
Wellness Program	MMB	WebMD
Vision Plan	SEGIP	Metropolitan Life

C. The Plan's Rights and Obligations

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

D. Uses and Disclosures of Your Protected Health Information

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

1. **Your authorization**. Except as outlined below, the Plan will not use or disclose Your PHI unless You have signed a form authorizing the use or disclosure. You may give the Plan written authorization to use your PHI or to disclose it to anyone for any purpose. You have the right to revoke that authorization in writing and the Plan will stop using or disclosing Your PHI in accordance with that authorization except to the extent that the

Plan has taken action in reliance upon the authorization. In addition, the Plan is required to obtain Your authorization under the following circumstances:

a. Psychotherapy Notes. Most uses and disclosures of psychotherapy notes will require Your authorization.
b. Marketing. Uses and disclosures of PHI which result in the Plan receiving financial payment from a third party whose product or services is being marketed will require Your authorization.
c. Sale of PHI. Disclosures that constitute a sale of PHI will require Your authorization.

2. **Payment.** The Plan may use and disclose PHI about You for all activities that are included within the definition of "payment" under the Privacy Rule, such as determining Your eligibility for Plan benefits, the eligibility of Your dependents, facilitating payment for Treatment and health care services You receive, determining benefit responsibility under The Plan, coordinating benefits with other Plans, or determining medical necessity. The definition of "payment" includes many more items, refer to the Privacy Rule for a complete list.
3. **Health care operations**. The Plan may use and disclose PHI about You for health care operations. These uses and disclosures are necessary to operate the Plan. This may include developing quality improvement programs, conducting pilot projects, developing new programs, as well as cost management purposes. The definition of "health care operation" includes many more items, refer to the Privacy Rule for a complete list.
The Plan will not sell your PHI. The Plan will not set Your premium or conduct underwriting for Your coverage using Your PHI. The Plan will not use Your genetic information for underwriting purposes. Plan Members are required to verify the eligibility of their dependents.
4. **Treatment**. The Plan does not provide Treatment. The Plan may use or disclose PHI for Treatment purposes. This includes helping Providers coordinate your healthcare. For example, a doctor may contact The Plan to ensure You have coverage or, in an emergency situation, to learn who are Your other Providers or to contact Your family members if You are unable to provide this information.
5. **Disclosures to the Plan Sponsor (Your Employer)**. The State of Minnesota, or your participating employer, is the Plan Sponsor. The Plan may disclose Your PHI to them to the extent necessary to administer the Plan. These disclosures may be made only to designated personnel at the administrative units of the Employer, usually the benefits department or Your Human Resources department, and will be limited to the disclosures necessary for Plan administration functions. Generally, this will include enrollment and billing information. These individuals will protect the privacy of Your PHI and will ensure that it is only used as described in this Notice and as permitted by law. Your PHI will not be used by the Employer for any employment-related actions or decisions or in connection with any other benefit plan offered by the Employer.
6. **Sponsored health plan programs**. The Plan may use or disclose Your PHI to a HIPAA-covered health care Provider, health plan, or health care clearinghouse, in connection with their Treatment, payment, or health care operations.
7. **Communications about product, service, and benefits**. The Plan may use and disclose Your PHI to tell You about possible medical Treatment options, programs, or alternatives, or to tell You about health-related products or services, including payment or coverage for such products or services, that may be of interest to You, provided the Plan does not receive financial remuneration for making such communications. The Plan may also use Your PHI to contact You with information about benefits under the Plan, including certain communications about Plan Networks, health plan changes, and services or products specifically related to a health condition You may have. The Plan may use and disclose Your PHI to contact You to provide reminders, such as annual check-ups, or information about Treatment alternatives or other health related benefits and services that may be of interest to You.
8. **Communications with individuals involved in Your Treatment and/or Plan payment**. Although the Plan will generally communicate directly with You about Your claims and

other Plan related matters that involve Your PHI, there may be instances when it is more appropriate to communicate about these matters with other individuals about Your health care or payment. This may include family, relatives, or close personal friends (or anyone else you may choose to designate).

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

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

9. **Research**. The Plan may use or disclose PHI for research purposes, provided that the researcher follows certain procedures to protect Your privacy. To the extent it is required by State law, The Plan will obtain Your consent for a disclosure for research purposes.
10. **De-Identified Data**. The Plan may create a collection of information that can no longer be traced back to You. This information does not contain individually identifying information.
11. **Business Associates**. The Plan may disclose Your PHI to a "business associate." The Plan's business associates are the individuals and entities the Plan engages to perform various duties on behalf of the Plan, or to provide services to the Plan. For example, the Plan's business associates might provide claims management services or utilization reviews. Business associates are permitted to receive, create, maintain, use, or disclose PHI, but only as provided in the Privacy Rule, and only after agreeing in writing to appropriately safeguard Your PHI pursuant to a business associate agreement.
12. **Other Uses and Disclosures**. The Plan may make certain other uses and disclosures of Your PHI without Your authorization:
    a. The Plan may use or disclose Your PHI for any purpose required by federal, state, or local law. For example, The Plan may be required by law to use or disclose Your PHI to respond to a court order, subject to further restrictions specified in this Notice below.
    b. The Plan may disclose Your PHI in the course of a judicial or administrative proceeding (for example, to respond to a subpoena or discovery request, subject to further restrictions specified in this Notice below.)
    c. The Plan may use or disclose Your PHI for public health activities that are permitted or required by law, including reporting of disease, injury, birth, and death, and for public health investigations.
    d. The Plan may disclose Your PHI to a public or private organization authorized to assist in disaster relief efforts. The Plan may use or disclose Your PHI to help notify a relative or other individual who is responsible for Your health care, of your location, general condition, or death. In such situations, if You are present and able to give Your verbal permission, the Plan will only use or disclose Your PHI with Your permission. This verbal permission will only cover a single encounter and is not a substitute for a written authorization. If You are not

present or are unable to give Your permission, the Plan will use or disclose Your PHI only if it determines (based on its professional judgment) that the use or disclosure is in Your best interest.

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

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

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

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

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

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

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

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

13. **Additional Restrictions on Use or Disclosure.** Some federal and state laws may require special privacy protections that restrict the use and disclosure of certain types of health information. Such laws may protect the following types of information: alcohol and substance use disorders, biometric information, child or adult abuse or neglect including sexual assault, communicable diseases, genetic information, HIV/AIDS, mental health, minors' information, prescriptions, reproductive health, and sexually transmitted diseases. The Plan will follow the more stringent law, where it applies to the Plan.

14. **Additional Privacy for Substance Use Disorder (SUD) Treatment**. Although the Plan is not a SUD treatment program, the Plan may receive information from a SUD program about Your treatment. The Plan will not disclose this information to be used in a civil, criminal, administrative, or legislative proceeding against You unless: (i) You provide Your written consent; or (ii) the Plan receives a court order accompanied by a subpoena or other legal requirement compelling its disclosure and You were given notice and an opportunity to respond to such court order. In addition, if the Plan uses this information to

raise funds for the Plan's benefit, the Plan must first provide You with a clear and conspicuous opportunity to elect not to receive any fundraising communications.

E. Your rights regarding Your Protected Health Information

You have the following rights relating to Your PHI:

1. **Right to access, inspect, and copy**. You have the right to look at or get copies of Your PHI maintained by the Plan that may be used to make decisions about Your Plan eligibility and benefits, with limited exceptions. The Plan may require You to make this request in writing to the Privacy Officer listed at the end of this Notice. Generally, the Plan will respond to Your request within 30 days after the Plan receives it; if more time is needed, the Plan will notify You within the original 30-day period. The Plan may deny Your request to inspect and copy in certain very limited circumstances. The Privacy Rule contains a few exceptions to Your right to inspect and copy Your PHI maintained by the Plan. You do not have the right to inspect or copy, among other things, psychotherapy notes or materials that are compiled in anticipation of litigation or similar proceedings. If Your written request is denied, You will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If the information You request is maintained electronically, and You request an electronic copy, the Plan will provide a copy in the electronic form and format You request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, the Plan will work with You to come to an agreement on form and format. If we cannot agree on an electronic form and format, the Plan will provide You with a paper copy. You have a right to choose to receive a copy of all or of only portions of your PHI. The Plan may charge a fee for copying or mailing Your PHI for You but may waive that charge depending on Your circumstances. If you make a request in advance, the Plan will provide You with an estimate of the cost of copying or mailing the requested information.
2. **Right to request an amendment of Your PHI**. If You believe that there is a mistake or missing information in a record of Your PHI held by the Plan or one of its vendors, You may request in writing, that the record be corrected or supplemented. You have the right to request an amendment for as long as the PHI is kept by or for the Plan. Your request must be in writing and must include a reason or explanation that supports Your request. The Plan, or someone on its behalf, will respond usually within 60 days of receiving Your request. The Plan may deny the request if it is not in writing, it is determined that the PHI is correct and complete, not part of the PHI kept by or for the Plan, not created by the Plan or its vendors, and/or not part of the Plan's or vendor's records (unless the person or entity that created the information is no longer available to make the amendment), or not part of the information which You would be permitted to inspect and copy. All denials will be made in writing. Any denial will include the reasons for denial and explain Your rights to have the request and denial, along with any statement in response that You provide, appended to Your PHI. If the Plan denies Your request for an amendment, You may file a written statement of disagreement, which the Plan may rebut in writing. The denial, statement of disagreement, and rebuttal will be included in any future disclosures of the relevant PHI. If Your request for amendment is approved, the Plan or the vendor, will change the PHI and inform You of the change and inform others that need to know about the change. If the Plan approves Your request, the Plan will include the amendment in any future disclosures of the relevant PHI.
3. **Right to request and receive an accounting of disclosures**. You have a right to receive a list of routine and non-routine disclosures that Plan has made of Your PHI. This right includes a list of when, to whom, for what purpose and what portion of your PHI has been released by the Plan and its vendors. This does not include a list of disclosures for Treatment, payment, health care operations, and certain other purposes (such as disclosures made for national security purposes, to law enforcement officials, or

correctional facilities). If the PHI disclosed is not an "electronic health record," the accounting will include disclosures for the six (6) years prior to the date of your request. In this case, as noted above, the accounting is not required to include all disclosures. If the PHI disclosed is an "electronic health record," the accounting will include disclosures up to three (3) years before the date of Your request. Your request for the accounting must be made in writing. Your request must include the time frame that You would like the Plan to cover (this may be no more than six (6) years before the date of the request). You will normally receive a response to Your written disclosure for this accounting within 60 days after your request is received. There will be no charge for up to one such list each year but there may be a charge for more frequent requests. The Plan will notify You of the cost involved and You may choose to withdraw or modify Your request at that time before any costs are incurred.

4. **Right to request restrictions**. You have the right to request that the Plan restrict how it uses or discloses Your PHI for Treatment, payment, or health care operations. You also have the right to request a limit on the PHI about You that the Plan discloses to someone who is involved in Your care or the payment of Your care, like a family member or friend. The Plan will consider Your request but generally is not legally bound to agree to the request for restriction. However, the Plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out Treatment); and (2) the PHI pertains solely to a health care item or service for which You, or another person on Your behalf, has paid the health care Provider or other covered entity involved in full. Your request must be in writing. In Your request, You must tell the Plan (1) what information You want to limit; (2) whether You want to limit the Plan's use, disclosure, or both; and (3) to whom You want the limits to apply, for example, disclosure to Your spouse. If the Plan does agree to Your restriction it must comply with the agreed to restriction, except for purposes of treating You in a Medical Emergency.
5. **Right to choose how the Plan contacts You**. You have the right to request that the Plan communicate with You about Your PHI by alternative means or to an alternative location. For example, you may request that the Plan only contact you at designated address or phone number. Your request must be in writing. In Your request, You must tell us how or where You wish to be contacted. The Plan will make a reasonable accommodation of Your request for confidential communication.
6. **Right to request a copy of this Notice in an alternative format**. You are entitled to receive a printed copy of this Notice at any time as well as a non-English translation. You may ask the Plan to give You a paper or electronic copy of this Notice at any time. Even if You have agreed to receive this Notice electronically, You are still entitled to a paper copy of this Notice. Contact the Plan using the information listed at the end of this Notice to obtain an alternative copy of this Notice.

F. Complaints

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

G. Contact Information for questions

If You have questions about this Notice or would like more information about the Plan's privacy

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

Minnesota Management and Budget

NOTICE OF INTENT TO COLLECT PRIVATE DATA

Minnesota Management and Budget (MMB) administers the State Employee Group Insurance Program (SEGIP). As an individual seeking to or participating in a group insurance program, you are asked to provide certain data for the purpose of the administration of group insurance benefits. This notice explains why MMB is requesting private data, how the data will be used, who has access to the data, and what may happen if you do not provide the requested data.

Use of Data. Data requested by MMB may be used for the following purposes:

- To determine eligibility for group insurance benefits
- To administer group insurance benefits
- As required by State and federal law, rule, or regulation

Right of Refusal. You are not required to provide any of the requested data. If you do not provide the requested data, group insurance program benefits may be denied or delayed for you, your spouse, or your dependent(s), as applicable.

Access to Data. The data that you provide may be shared with:

- Authorized personnel whose jobs reasonably require access
- Insurance and service providers, and other contracted vendors
- Any other person or entity authorized by federal or state law to access the data, including but not limited to the Office of the Legislative Auditor, the Minnesota Department of Health, the Minnesota Department of Commerce, or others as authorized by a court order

The parents of a minor may access private data about the minor unless there is a law, court order, or other legally binding instrument that blocks the parent from accessing the data.

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DELTA DENTAL OF MINNESOTA

SUMMARY OF BENEFITS

This is a summary of your Group Dental Program prepared for Persons Covered under the

STATE OF MINNESOTA
DELTA DENTAL GROUP NO. 216
STATE DENTAL PLAN

This Program has been established and is maintained and administered in accordance with the provisions of Dental Master Group Contract Number 216 issued by Delta Dental of Minnesota to Minnesota Management and Budget.

SECTION 1
1.01 USING YOUR DENTAL PROGRAM

Please note that **Dentists** may fall into three categories:

- **In-Network - Dentists** who participate in the network for the **State Dental Plan – Delta Dental** Preferred Provider Organization (PPO). If you receive dental services from a **Dentist** who participates in the **State Dental Plan – Delta Dental network**, you will receive your highest benefit with the lowest costs for services.

- **The National Network** – Delta Dental includes Dentists that participate in the Delta Dental Preferred Provider Organization (PPO) and the Delta Dental Premier Network. Providers participating in the National Network are available for all states except Minnesota. If you receive dental services from a dentist who participates in the National Network, your costs will fall in between the in-network and out-of-network benefits.

- **Out-of-Network - Dentists** who do not participate in the network for the **State Dental Plan – Delta Dental** PPO nor the National Network, are all considered **Out-of-Network**. If you receive dental services from an **Out-of- Network** provider, You will receive the lowest benefit with the highest cost for services.

At the time of your first dental appointment, it is very important to advise your Dentist of the following information:

- **Your Delta Dental group number (State Dental Plan, Group 216)**
- **Your Employer (State of Minnesota)**
- **Your identification number**
  (your dependents must use your identification number)
- **Your birthday and the birth dates of your spouse and dependent children**

I**n order to avoid misunderstandings as to the participating status of your Dentist, we suggest that you ask your dental office if they participate in the PPO network created by Delta Dental for State of Minnesota employees (referred to as State Dental Plan – Delta Dental) at the time you call for an appointment. This program is often recognized by Dentists as Group 216.**

If your **Dentist** is a **Participating Dentist** with **State Dental Plan – Delta Dental** or part of the **National Network**, the **Claim Form** will be available at the **Dentist**'s office. **Out-of-Network Dentists** may also have **Claim Form**s available for your convenience.

If your **Dentist** is non-participating with **State Dental Plan – Delta Dental**, **Claim Forms** are available by calling **Delta Dental of Minnesota (651) 406-5916 or (800) 553-9536,** or on the Internet at https://www.DeltaDentalMN.org/segip. **Delta Dental** accepts the standard American Dental Association (ADA) **Claim Form** used by most **Dentists**.

The dental office normally will file the **Claim Form** with **Delta Dental**; however, you may be required to assist the dental office in completing the patient information portion on the **Claim Form** (Items 1-14).

Pretreatment Estimate of Benefits

After the initial examination, your Dentist will establish the dental treatment to be performed. If the necessary dental treatment involves major restorative, periodontics, prosthetics or orthodontic care, a State Dental Plan - Delta Dental Dentist will submit a Claim Form or a request for a pre-estimate of benefits to Delta Dental outlining the proposed treatment. (Many Out-of-Network Dentists will submit a pre-estimate of costs to Delta Dental upon your request.)

Delta Dental will then send to you and your dentist a Pretreatment Estimate of Benefits that will help you understand what your financial obligation is estimated to be if the treatment is completed. The Pretreatment Estimate of Benefits is a valuable tool for both the dentist and the patient. A Pretreatment Estimate will outline the patient's responsibility to the dentist with regard to co-payments, deductibles, and non-covered services, and allows the dentist and the patient to make any necessary financial arrangements before treatment begins.

A Pretreatment Estimate of Benefits DOES NOT prior authorize treatment, determine dental necessity or serve as a guarantee of payment by the Plan or Delta Dental. These estimates will be subject to your continuing eligibility in the Plan and the Contract remaining in effect. In addition, the amount of actual payment that may be made under the Plan may differ from the amount on the Pretreatment Estimate if: (1) there is other coverage with which the Plan coordinates coverage (see Coordination of Benefits "COB," Section 8); (2) other claims are received and paid under the Plan between the date of issuance of the Pretreatment Estimate and the receipt of the claim for completion of the proposed dental treatment identified on the pre-estimate treatment plan as submitted to Delta Dental; or (3) the services on the treatment plan are not covered under the Plan.

1.02 SUMMARY OF DENTAL BENEFITS

Your dental program pays the following percentages up to a maximum fee per procedure. The maximum fee allowed under the **State Dental Plan – Delta Dental** is different for **State Dental Plan Network – Delta Dental Dentists** and **Dentists** who are not in the **State Dental Plan Network – Delta Dental** network (referred to as **Out- of-Network Dentists)**. The maximum fee allowed under the **National Network – Delta Dental** is different for **National Network – Delta Dental Dentists** and **Dentists** who are not in the **National Network – Delta Dental** network (referred to as **Out- of-Network Dentists)**. In addition, a higher **Deductible** is applied to some services received from an **Out- of-Network Dentist** who is not a **State Dental Plan – Delta Dental Dentist** nor a **National Network – Delta Dental Dentist**. If you see an **Out-of-Network Dentist**, your out-of-pocket expenses will increase. **Out-of-Network Dentists** may bill up to their full charges for any difference between the Plan payment and the **Dentist**'s full charge. You will be responsible for all treatment charges made by an **Out-of-Network Dentist**. You may be asked to pay for treatment in advance and Delta Dental will pay the allowable benefit to you directly.

See Section 9 for further information on types of benefits covered.

	State Dental Plan		
Service	**State Dental Plan Network**	**National Network**	**Out-of-Network**
COVERAGE A - Diagnostic and Preventive Services	100%	100%	50%
COVERAGE B1a - Basic Services	80%	60%	50%
COVERAGE B1b – Endodontics	80%	60%	50%
COVERAGE B1c - Periodontics	80%	60%	50%
COVERAGE B1d - Oral Surgery	80%	60%	50%
COVERAGE B2 - Major Restorative Services	80%	60%	50%
COVERAGE C – Prosthetics, Prosthetic Repairs and Adjustments	80%	60%	50%
COVERAGE D - Orthodontics	80%	60%	50%

National Network benefits apply for members who see a dental provider outside of Minnesota that is in their dental plan administrator's national network but not the State Dental Plan network.

Deductible:

State Dental Plan – Delta Dental Network: There is a $50 deductible per Covered Person each Coverage Year not to exceed three (3) times that amount per Family Unit for services rendered by a State Dental Plan – Delta Dental Network dentist. The deductible does not apply to Diagnostic and Preventive or Orthodontic Services.

National Network – Delta Dental: There is a $100 deductible per Covered Person each Coverage Year not to exceed three (3) times that amount per Family Unit for services rendered by a State Dental Plan – Delta Dental Network dentist. The deductible does not apply to Diagnostic and Preventive or Orthodontic Services.

Out-of-Network Dentist: If you receive dental care from an **Out-of-Network Dentist** who does not participate in the **State Dental Plan – Delta Dental** network, there is a $125 **Deductible** per Covered Person each **Contract Year**. The **Deductible** does not apply to Coverages A and D regardless of whether the **Dental Services** were received from a **State Dental Plan – Delta Dental Dentist** or an **Out-of-Network Dentist**.

See Section 12, page 42, for important information about the amounts Delta Dental will pay for services rendered by dentists who do not participate with Delta Dental.

Maximum Benefits Payable:

1. A **Contract Year** maximum will apply to all benefits payable by **Delta Dental** under Coverages B1, B2, C of the **Contract**. Each Covered Person is subject to a $2,200.00 maximum amount payable for the **Contract Year**. The **Contract Year** maximum benefit is applicable to all coverages received **In or Out-of-Network, except Diagnostic, Preventive Services, and Orthodontia**. A separate lifetime maximum benefit of $3,200.00 will apply to Orthodontic (Coverage D) Services per **Eligible Covered Persons.**

1.03 ADDITIONAL DENTAL PROGRAM PROVISIONS:

A. Term of Contract:

1. The term of the **Contract is January 1 through December 31, and will renew for additional one-year terms, unless terminated by Delta Dental or Minnesota Management and Budget.**

Coverage will begin at 12:00:00 a.m. and end at 11:59:59 p.m. (Central Standard Time).

2. The **Contract Year** for which **Deductibles**, if any, and maximums are to be applied will be measured from the beginning and end dates of coverage determined by Minnesota Management and Budget.

B. Eligibility:

Minnesota Management and Budget will determine who constitutes an **Eligible Employee** or Dependent for the purpose of participating in the State Employee Group Insurance Program (SEGIP). These decisions are binding on **Delta Dental**.

A summary of individuals currently eligible as Dependents is contained in Section 2, paragraph 2.13 of the Definitions.

C. Effective Date of Coverage:

The initial effective date of coverage is the 30th calendar day after the first day of employment, reemployment, or reinstatement. The initial effective date of coverage for an employee whose eligibility has changed is the date of the change. An Employee must be actively at work on the initial effective date of coverage or coverage will be delayed until the date the Employee returns to active payroll status. Notwithstanding the foregoing, if the Employee is not actively at work on the initial effective date of coverage due to the employee's or dependent's health status, medical condition, or disability, as such terms are defined in Section 9802(a) of the Internal Revenue Code and the regulations related to that section, coverages shall not be delayed.

If an **Eligible Employee** and their Dependents apply for coverage during an **Open Enrollment** period, coverage will become effective on the date specified by MMB.

Adopted children are covered from the date of placement for the purposes of adoption, and dependents with a disability are covered from the Employee's effective date of coverage even though they are hospitalized on the effective date of coverage.

A newborn child's coverage takes effect from the moment of birth.

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

For the purposes of this entire section, a Dependent's coverage may not take effect prior to an Employee's coverage.

D. Termination of Coverage:

The events giving rise to the termination of coverage with respect to any covered person are detailed in Section 5.

E. Open Enrollment:

Open Enrollment under the **Contract** will be at the times established by Minnesota Management and Budget.

F. Off-Cycle Enrollment:

A covered person and their eligible Dependents will be allowed to make an enrollment choice outside of the dental **Open Enrollment** period or initial period of eligibility within thirty (30) calendar days of the events specified below. Decisions as to whether these circumstances occur are at the sole discretion of MMB and are binding on **Delta Dental**.

1. The dental claim administrator participating in the SEGIP is placed into rehabilitation or liquidation or is otherwise unable to provide the services specified in the master group **Contract** or Summary of Benefits.

2. Any dental claim provider participating in the SEGIP loses all or a portion of its dental provider network to the extent that services are not accessible or available within thirty (30) miles of the work station, including withdrawal from an approved service area.

3. Any dental claim administrator participating in the SEGIP terminates or is terminated from participation in the program.

4. An Employee moves to a location outside of the service area if access to dental coverage is impacted.

5. A covered Employee, defined as an employee already enrolled in coverage, may add coverage for all **Eligible Dependents** after the following events:

    a. When an Employee marries;

    b. If an Employee's Dependent loses dental coverage, the Employee may add Dependent coverage. Loss of coverage includes any involuntary changes in coverage which result in termination of a Dependent's coverage, regardless of whether it is immediately replaced by other subsidized coverage. Loss of coverage does not include the following:

        I. A change in carriers through the same employer where the coverage is continuous and uninterrupted;

        II. A change in a Dependent's dental plan benefits levels; and

        III. A voluntary termination by the Dependent, including but not limited to termination or reduction of coverage due to the adoption of cafeteria-style plans.

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

    c. When an Employee acquires their first Dependent child.

6. A former legislator and their Dependents may elect coverage at any time; however, a former legislator's **Eligible Dependent** may not be enrolled for coverage unless the former legislator is also enrolled for coverage.

7. Retirees may elect to designate another carrier in the (60) sixty days immediately preceding the effective date of retirement.

8. As otherwise specified by the MMB.

G. Retirement:

An Employee who is retiring from state service or any group that is eligible to participate in the SEGIP and who is eligible to maintain participation in the SEGIP as determined by MMB may, consistent with state law, indefinitely maintain dental coverage with the State Employee Group Insurance Program by filling out the proper forms with their agency within thirty (30) days after the effective date of their retirement.

If a retiring Employee fails to make a proper election within the thirty (30) day-time period, the retiring Employee may continue coverage for up to eighteen (18) months in accordance with state and federal law. See the section entitled "Continuation of Coverage" for information on your continuation rights.

In any event, failure to pay the premium will result in termination of coverage. Once coverage has been terminated for any reason, voluntarily or involuntarily, the Retiree, Early Retiree, and/or their Dependents may not rejoin the SEGIP.

SECTION 2
Definitions

The following terms, words and phrases shall, for purposes of this **Contract**, be defined as follows:

2.01 "**Allowable Charge**" and "**Allowable Charges**" The lesser of: (1) the Allowed Fee as determined by **Delta Dental**; or, (2) the fee actually charged to the patient; or, (3) the fees regularly offered to the patient; or, (4) the amount actually accepted as payment in full by the **Dentist** irrespective of the amount charged. (All **"Allowable Charges"** are determined solely by **Delta Dental** prior to the application of all copayments and **Deductibles** as provided in the Schedule of Benefits.)

2.02 "**Applicable Percentage**" The level specified in Section 1, paragraph 1.02 which will be applied to the **Allowable Charges** to determine **Delta Dental's** benefit obligation with respect to any **Covered Dental Procedure**.

2.03 "**Attending Dentist Statement**" or "**Claim Form**" The written document required to be submitted to **Delta Dental** to substantiate any claim under this **Contract** for dental care and treatment performed or to be performed on a Covered Person.

2.04 **"Continuation of Coverage Qualifying Event"** The happening of certain events such as employment termination, divorce, death of an **Eligible Employee** and other events specified in Section 6 of this Summary of Benefits ["Continuation of Coverage"] the occurrence of which may entitle an **Eligible Employee** and their **Eligible Dependents** to continue coverage under this C**ontract**.

2.05 "**Contract Date**" The date determined by Minnesota Management and Budget upon which this **Contract** becomes effective.

2.06 "**Contract Documents**" All written documents comprising the **Contract** between the **Group Subscriber** and **Delta Dental** including but not limited to the Administrative Agreement, Master Group **Contract** and this Summary of Benefits, amendments or addenda to such documents entered into and signed by the **Group Subscriber** and **Delta Dental** on or after the **Contract Date**.

2.07 "**Contract Term**" The period of time set forth for each subgroup under Section 1, paragraph 1.03(A)(1).

2.08 "**Contract Year**" The period of time determined by Minnesota Management and Budget during which applicable **Contract Deductibles** and maximums will apply for each Covered Person.

2.09 **"Covered Dental Service**," "**Dental Services**," and "**Dental Procedures**" The providing of dental care or treatment by a **Dentist** to a Covered Person while this **Contract** is in effect provided that such care or treatment is recognized by **Delta Dental** as a generally accepted form of care or treatment according to prevailing standards of dental practice.

2.10 "**Deductible**" That amount of **Allowable Charges** specified in Section 1, paragraph 1.02 for which **Delta Dental** will not make any benefit payment.

2.11 "**Delta Dental**" Delta Dental of Minnesota, a Minnesota non-profit health service plan corporation which maintains its principal place of business at 500 Washington Avenue South, Suite 2060, Minneapolis, MN 55415-1163

2.12 "**Dentist**" A doctor of dentistry duly licensed and registered to practice the profession of dentistry and whose license is in good standing with the appropriate licensing or governing body of the State of Minnesota, any other state of the United States, a territory of the United States, a foreign country or other similar jurisdiction.

2.13 "**Eligible Dependents**" MMB determines the eligibility of Dependents subject to Collective Bargaining Agreements and Compensation Plans which may change during a Contract Year. If two

or more Employees participate in the SEGIP, then only one of the Employees may cover their mutual Dependents. Delta Dental agrees to accept the decision of MMB as binding.

Currently, **Eligible Dependents** include the following:

A. Spouse.
An Employee's spouse (if legally married under Minnesota law). If both spouses work for the State or another organization participating in the State's Group Insurance Program, a spouse may be covered as a dependent by the other employee. If the Employee's spouse works full-time for an employer (with more than 100 people) and (1) elects to receive either credits or cash in place of health insurance or health coverage or towards some other benefit in place of health insurance; or (2) is enrolled in a high deductible medical insurance plan (as defined by the IRS) that includes a contribution to a health savings account (HSA) through their employing organization, then they are not eligible for medical coverage and are not considered to be an Eligible Dependent.

B. Child.
A "dependent child" includes an employee's: (1) biological child, (2) child legally adopted by or placed for adoption with the employee, (3) stepchild, (4) foster child, (5) child by legal guardianship, and (6) child by placement to the employee, who is a relative to the child, as established by court judgment, order, or decree For a stepchild to be considered a dependent child, the employee must be legally married to the child's legal parent or legal guardian. For a foster child to be considered a dependent child under this plan, the foster child must be placed with the employee or the employee's spouse by an authorized placement agency or by a judgment, decree or other court order. For a child by legal guardianship or placement to be considered a dependent child under this plan, the child's legal relationship with the employee must be established by a court judgment, decree, or other court order. A dependent child is generally eligible to age 26, unless the child's status as a dependent child ceases at an earlier date, such as the expiration of a court order or decree.

   a. Coverage under only one plan: If the employee's child works for the state or another organization participating in the State's Group Insurance Program, the child may be covered as a dependent by the employee until the child reaches 26. If the child reaches age 26 while employed and covered by a SEGIP parent, the child must contact SEGIP no later than 30 days from the 26th birthday to enroll in their own insurance policy.

C. Grandchild.
A grandchild of an employee, to age twenty-five (25), is an eligible dependent grandchild who is financially dependent upon the employee for principal support and maintenance and has resided with the employee continuously from birth. A grandchild of an employee is also an eligible dependent if the grandchild is claimed as a tax dependent on employee's tax return. If a grandchild is legally adopted or placed in the legal custody of the grandparent (foster child), they are covered as a dependent child as specified under 2.13 B or 2.13 D.

D. Child with a disability.
A dependent child that is disabled is an eligible employee's child or grandchild regardless of marital status, who was disabled prior to the limiting age or any other limiting term required for dependent coverage and who continues to be incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder or physical disability, and is chiefly dependent upon the Employee for their support and maintenance, provided proof of such incapacity and dependency is furnished to the Dental Administrator by the employee or enrollee within thirty one (31) days of the child's attainment of the limiting age or any other limiting term required for dependent coverage. If the Dependent is 26 years of age or older at the time of the Employee's enrollment or initial employment, then the Employee must provide **Delta Dental** with proof that the Dependent meets these requirements in a form acceptable to **Delta Dental**. The Dependent that has a disability shall be eligible for coverage as long as they continue to be disabled and dependent, unless coverage otherwise terminates under the **Contract.**

E. Qualified Medical Child Support Order.
A child who is required to be covered by a Qualified Medical Child Support Order (QMCSO) is considered an eligible dependent. Participants and beneficiaries can obtain, without charge, a copy of procedures governing Qualified Medical Child Support Orders ("QMCSOs") from the Plan Administrator.

F. Child Coverage Limited to Coverage under One Employee.
If both spouses work for the State or another organization participating in the State's Group Insurance Program, either spouse, but not both, may cover the eligible dependent child or grandchild. This restriction also applies to two divorced, legally separated, or unmarried employees who share legal responsibility for their eligible dependent child or grandchild.

2.14 **"Eligible Employee(s)"** Any Employee who is determined to be eligible for coverage under this **Contract** by Minnesota Management and Budget. [See Section 1, paragraph 1.03(B)]

2.15 **"Enrollee"** Any person covered under the **Contract** other than as a dependent.

2.16 **"Estimate of Benefits"** Means a document sent by **Delta Dental** to a **Covered Person** that will detail the benefits under the Plan and informs the **Covered Person** of the estimated payment obligations prior to commencing the treatment.

2.17 **"Family Unit"** The covered Employee and their eligible Dependents.

2.18 **"Group Dental Master Group Contract," "Contract", "State Dental Plan – Delta Dental"** and **"Plan"** The written agreement between the State of Minnesota and **Delta Dental** consisting of the **Contract** and those additional **Contract Documents** listed and described in Section 2.06.

2.19 **"Group Subscriber"** The State of Minnesota Management and Budget.

2.20 "**In-Network**" or "**State Dental Plan – Delta Dental Dentists**: Means **Dental Services** provided by a **Dentist** who is participating in the **State Dental Plan** – Delta Dental and is a **State Dental Plan – Delta Dental Dentist**.

2.21 **"Maximum Benefits"** With respect to all benefits the annual limit of claim payments specified in Section 1, paragraph 1.02.

2.22 "**National Network**" or "**National Network – Delta Dental Dentists**: Means **Dental Services** provided by a **Dentist** who is participating in the **Delta Dental Preferred Provider Organization (PPO)** or the **Delta Dental Premier Network**. Providers participating in the **National Network – Delta Dental** are available for all states except Minnesota and are not a **State Dental Plan – Delta Dental** provider. A **Dentist** who has signed and filed a Dentist Membership and Participating Provider Agreement for the **National Network– Delta Dental** and has agreed to accept the maximum allowable **National Network – Delta Dental** PPO or Premier Network fee as full payment as determined by **Delta Dental**.

2.23 **"Open Enrollment"** The period of time during which an **Eligible Employee** may elect, while this **Contract** is in effect, to add coverage under this **Contract** for themselves, or their Dependents as provided for in paragraph 1.03(E).

2.24 **"Other Coverage"** The coverage provided by any other organization subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, by any other medical, dental or hospital service organization, or by similar plans or by union welfare plans, or Employee or employer benefit organizations or by health maintenance organizations, preferred provider organizations, exclusive provider organizations providing benefits of any kind for **Dental Procedures** or services. **"Other Coverage"** excludes group hospital indemnity policies of $100 per day or less, student accident policies and individual dental payment plans or policies.

2.25 "**Out-of-Network Dentist**" A **Dentist** who has signed and filed with **Delta Dental** a Dentist Membership and Participation Agreement but is not a **State Dental Plan – Delta Dental Dentist** or a **Dentist** who does not participate in any **Delta Dental** network.

2.26 "**Program" or "Dental Program**" Means the same as "Group Contract". See section 2.18.

2.27 **"State Dental Plan – Delta Dental Dentist"** or "**In-Network Dentist**" A **Dentist** who participates in the network of PPO Providers for the State of Minnesota Employees **(State Dental Plan – Delta Dental**). A **Dentist** who has signed and filed a Dentist Membership and Participating Provider Agreement for the **State Dental Plan – Delta Dental** and has agreed to accept the maximum allowable **State Dental Plan – Delta Dental** PPO fee as full payment as determined by **Delta Dental**.

2.28 **"Total Disability"** The Employee's inability to engage in or perform the duties of the Employee's regular occupation or employment within the first two years of the date of disability, and, thereafter, the Employee's inability to engage in any paid employment or work for which the Employee may, by education and training, including rehabilitative training, be or reasonably become qualified.

2.29 "**Treatment Plan**" A written outline of the planned program of dental care and treatment performed or to be performed on a Covered Person by a **Dentist** after examination of the Covered Person and submitted on a form acceptable to **Delta Dental** and with such documentation as may be required by **Delta Dental**.

SECTION 3
Clerical Error

3.01 Employer or **Delta Dental** Error:

An Employee or their dependents may not be deprived of coverage under this **Contract** because of employer or **Delta Dental** error. **Delta Dental** agrees to make adjustments under this provision for a period of up to twelve months from the effective date of the error, as specified by Minnesota Management and Budget. This provision will not prohibit adjustments beyond a twelve-month period if agreed upon by **Delta Dental** and Minnesota Management and Budget.

SECTION 4
PLAN PAYMENTS

Payment to Physicians

4.01 Notwithstanding any language within the **Contract** to the contrary, benefits under this **Contract** shall be performed by a duly licensed **Dentist** provided that such procedures can be lawfully performed within the scope of the licensure of a duly licensed **Dentist**.

Covered Fees

4.02 Under this Program, YOU ARE FREE TO GO TO THE **DENTIST** OF YOUR CHOICE. You will have additional out-of-pocket costs if your **Dentist** is not a **State Dental Plan** – **Delta Dental Dentist** and not a **National Network- Delta Dental Dentist**. This payment difference could result in some financial liability to you beyond the usual indemnity features of the program. The amount is dependent on the **Out-of-Network Dentist's billed Fees** in relation to the **State Dental Plan** – **Delta Dental** amount determined by **Delta Dental**.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR **DENTIST** ABOUT THEIR PARTICIPATION STATUS WITH THE **STATE DENTAL PLAN – DELTA DENTAL** PPO NETWORK FOR STATE EMPLOYEES PRIOR TO RECEIVING DENTAL CARE. NOT ALL **DENTISTS** WHO PARTICIPATE WITH OTHER COMMERCIAL **DELTA DENTAL** PRODUCTS PARTICIPATE IN THE **STATE DENTAL PLAN – DELTA DENTAL.**

Claim Payments

4.03 **State Dental Plan – Delta Dental Dentists**:

Claim payments are based on the **Allowable Charges** which are the lesser of:

1. the normal (most frequently charged) fee for the dental procedure(s), uniformly charged to patients or third-party payors;
2. the amount for participating **Dentists** in the **State Dental Plan – Delta Dental** administered by **Delta Dental;**
3. the fees actually charged for dental services provided to a Covered Person under the plan;
4. the fees regularly offered to patients; or
5. the amount actually accepted as payment in full by the **Dentist** irrespective of the amount charged.

The summary of Dental Benefits is as shown in Section 1, Paragraph 1.02. The **State Dental Plan** – Delta Dental **Dentist** will receive the claim payments directly.

National Network Plan – Delta Dental Dentists:

Claim payments are based on the **Allowable Charges** which are the lesser of:

1. the normal (most frequently charged) fee for the dental procedure(s), uniformly charged to patients or third-party payors;
2. the amount for participating **Dentists** in the **National Network Plan – Delta Dental** administered by **Delta Dental;**
3. the fees actually charged for dental services provided to a Covered Person under the plan;
4. the fees regularly offered to patients; or
5. the amount actually accepted as payment in full by the **Dentist** irrespective of the amount charged.

The summary of Dental Benefits is as shown in Section 1, Paragraph 1.02. The **National Network Plan** – Delta Dental **Dentist** will receive the claim payments directly

Out-of-Network Dentists:

Claim payments for **Dentists** other than **State Dental Plan – Delta Dental Dentists** or **National Network – Delta Dental Dentists** are based on the "**Allowable Charges**" which are the lesser of:

1. the **Out-of-Network** amount as administered by Delta Dental for **Dental Services** provided by any **Out-of-Network Dentist,**
2. the fees actually charged to the Covered Persons
3. the fees regularly offered to patients
4. the amount actually accepted as payment in full by the **Dentist** irrespective of the amount charged.

If the **Out-of-Network Dentist** participates with any other commercial **Delta Dental** dental plan, the claim payments are sent directly to the **Dentist**. If the **Out-of-Network Dentist** does not participate with any commercial **Delta Dental** dental plan, the claim payments are sent directly to the Covered Person when services are rendered by an **Out-of-Network Dentist**, unless benefits are authorized by the Covered Person to be paid directly to the provider and required by applicable state law.

THE COVERED PERSON IS RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY **DENTISTS** WHO DO NOT PARTICIPATE IN THE **STATE DENTAL PLAN – DELTA DENTAL** or **National Network – Delta Dental Dentists**.

Delta Dental administers payments in accordance with the Group **Contract** only when the **Covered Dental Procedures** have been completed. Temporary or incomplete procedures are not **Covered**

Services. Temporary procedures include but are not limited to; sedative fillings, temporary fillings and temporary crowns.

SECTION 5
Termination of Coverage

5.01

Coverage for You and/or Your dependents will terminate on the earliest of the following dates, except that coverage may be continued in some instances as specified in Continuation of Coverage (see Section 6,).

a) For You and Your dependents, the date that either the **DELTA DENTAL** or Minnesota Management and Budget terminates the Plan.

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

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

d) For You and Your dependents, following the receipt of a written request, the coverage will end on the last day of the month in which a life event occurred. Approval to terminate coverage will only be granted if the request is consistent with a life event. Life events include, but are not limited to:

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

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

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

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

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

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

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

k) An employee or dependent found to be ineligible will be dropped from coverage as of the date of ineligibility or, if the date of ineligibility has passed then on the first day of the month following the date in which the employee or dependent was found to be ineligible. If the employee or dependent was found eligible based on fraud or an intentional misrepresentation of a material fact then the loss of coverage will be retroactive to the first day of ineligibility. Inadvertent or negligent failures to update or correct information related to eligibility of an employee's listed dependent may subject the employee and/or dependent to pay for the cost of coverage, which may be the COBRA continuation rate and/or any claims paid by the plan. If the Plan Sponsor erroneously enrolled an employee or a dependent, coverage may be terminated retroactively to the first day of ineligibility if the Plan Sponsor obtains the written consent from the employee or dependent authorizing the retroactive termination of coverage.

SECTION 6
Continuation of Coverage

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

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

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

There may be other health coverage options for you and your family. You may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. COBRA eligibility does not limit or exclude your eligibility for a health coverage tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within their specified timeframe.

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

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

4. You become divorced or legally separated from Your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:
1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than their gross misconduct; or
4. The child stops being eligible for coverage under the Plan as a "dependent child."

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

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

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

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

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

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

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

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

Second qualifying events

1. Extension of 18-month period of continuation coverage

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

2. Disability extension of 18-month period of continuation coverage

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

Continuation coverage for employees who retire or become disabled

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

If You have questions

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

Keep the Employer Informed of Address Changes

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

Cost Verification

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

Special Second Election Period

Special continuation rights apply to certain employees who are eligible for the health coverage tax credit. These employees are entitled to a second opportunity to elect continuation coverage for themselves and certain family Members (if they did not already elect continuation coverage) during a special second election period. This election period is the 60-day period beginning on the first day of the month in which an eligible employee becomes eligible for the health coverage tax credit, but only if the election is made within six months of losing coverage. Please contact the Plan Administrator for additional information.

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

Retirement

An employee who is retiring from state service or any group that is eligible to participate in the SEGIP and who is eligible to maintain participation in the SEGIP as determined by MMB may, consistent with state law, indefinitely maintain dental coverage with the SEGIP by filling out the proper forms with their agency within 30 days after the effective date of their retirement.

If a retiring employee fails to make a proper election within the 30-day time period, the retiring Employee may continue coverage for up to 18 months in accordance with state and federal law. See item 13 for information on Your continuation rights.

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

SECTION 7

Possible Direct Payment to Provider upon Request of Noncustodial Parent

7.01 When **Dental Services** covered under the **Contract** are rendered by a Dentist to a Dependent of an **Eligible Employee** who has legal responsibility for that Dependent's dental care but who does not have custody of the Dependent, **Delta Dental** may, upon request of the custodial parent, make payments directly to the provider of the dental care.

SECTION 8

Claims Covered in Whole or Part by Other Coverage (Coordination of Benefits)

Unless otherwise indicated, on any claim hereunder for which there is **Other Coverage**, as defined in 2.23 of the Definitions section of this **Contract**, the maximum obligation of **Delta Dental** shall not exceed the **Allowable Charges** as defined in Section 2, paragraph 2.01, Definitions, and, in addition shall be no greater than is sufficient when added to what has been paid or may be payable under the **Other Coverage**, to equal **Delta Dental's Allowable Charges** for the **Dental Services** involved in the claim.

8.01 A Covered Person shall not be deemed to have Other **Coverage** when the other organization is insolvent.

8.02 Coordination of Benefits under the **Contract** by **Delta Dental**, when applied, shall be consistent with the Minnesota Department of Commerce rules on coordination of benefits part 2742.0100-2742.0400.

8.03 Coordination of Benefits shall not apply, with respect to Other **Coverage**, when the other **Coverage** available is under no-fault automobile insurance.

SECTION 9
Types of Benefits Covered

9.01 **Delta Dental** will pay for **Dental Procedures** performed by **Dentists** on **Eligible Employees** or **Eligible Dependents** in accordance with the **Contract** and Definitions. The **Dental Services** under the **Contract** are those coverages which are shown in the Summary of Dental Benefits, Section 1.02.

Any coverage not included in the Summary of Dental Benefits section is excluded. New or experimental techniques or **Dental Procedures** may be denied until there is, to the satisfaction of **Delta Dental**, an established scientific basis for recommendation thereof.

9.02 As a condition precedent to the approval of claims hereunder, **Delta Dental** shall be entitled to request and receive, to such extent as may be lawful, from any attending or examining **Dentist**, or from hospitals in which dental care is provided, such information and records relating to an **Eligible Employee** or **Eligible Dependent** as may be required in the administration of such claims, or to require that an **Eligible Employee** or **Eligible Dependent** be examined by a dental consultant retained by **Delta Dental** in or near their place of residence; provided, however, that **Delta Dental** shall in every case hold such information and records as confidential.

9.03 **COVERAGE A: Diagnostic and Preventive Services**

Oral Evaluations - Covered 2 times per Contract Year.

NOTE: Comprehensive oral evaluations will be benefited 1 time per dental office, subject to the two (2) times per Contract Year limitation. Any additional comprehensive oral evaluations performed by the same dental office will be benefited as a periodic oral evaluation and will be subject to the two (2) times per Contract Year limitation.

Limited Oral Evaluation - Covered once per Contract Year and are separate from all other oral evaluations.

Radiographs (X-rays)

- **Bitewings** - Covered at 1 series of films per 12-month period.
- **Full Mouth (Complete Series) or Panoramic** - Covered 1 time per 36-month period.
- **Periapical(s)**
- **Occlusal** - Covered at 1 series per 12-month period.

Dental Cleaning

- **Prophylaxis** - Covered 2 times per Contract Year.

  Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

  NOTE: A prophylaxis performed on a Covered Person under the age of 14 will be benefited as a child prophylaxis. A prophylaxis performed on a Covered Person age 14 or older will be benefited as an adult prophylaxis.

- **Periodontal Maintenance** - Covered 4 times per Contract Year.

  Periodontal Maintenance is a procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Fluoride Treatment (Topical application of fluoride) - Covered 1 time per 12-month period for dependent children through the age of 18.

Silver Diamine Fluoride – Covered 2 times per calendar year, per tooth.

Space Maintainers - Covered 1 time per lifetime on eligible dependent children through the age of 16 for extracted primary posterior (back) teeth.

LIMITATION: Repair or replacement of lost/broken appliances is not a covered benefit.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered 1 time per lifetime for permanent first and second molars of eligible dependent children through the age of 18.

EXCLUSIONS - Coverage is NOT provided for:

1. Oral Hygiene Instructions.

9.04 **COVERAGE B1a: Basic Services**

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

- **Anterior (front) Teeth** - Treatment to restore decayed or fractured permanent or primary anterior teeth.
- **Posterior (back) Teeth** - This service is not covered under Basic Services. Refer to the Complex or Major Restorative Services section of your benefits.

Other Basic Services

- **Restorative cast post and core build-up, including pins and posts** - See benefit coverage description under Complex or Major Restorative Services.

- **Pre-fabricated or Stainless-Steel Crown** - Covered 1 time per 24-month period for eligible dependent children through the age of 18.

Adjunctive General Services

- **Intravenous Conscious Sedation and IV Sedation** - Covered when performed in conjunction with complex surgical service.

  LIMITATION: Intravenous conscious sedation and IV sedation will not be covered when performed with non-surgical dental care.

EXCLUSIONS - Coverage is NOT provided for:

1. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care.
2. Case presentation and office visits.
3. Athletic mouthguard, enamel microabrasion, and odontoplasty.
4. Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes, but is not limited to whitening agents, tooth bonding and veneers.
5. Placement or removal of sedative filling, base or liner used under a restoration.
6. Amalgam or composite restorations placed for preventive or cosmetic purposes.

9.05 **COVERAGE B1b: Endodontics**

Endodontic Therapy on Primary Teeth

- **Pulpal Therapy**
- **Therapeutic Pulpotomy**

Endodontic Therapy on Permanent Teeth

- **Root Canal Therapy**
- **Apicoectomy**
- **Root Amputation on posterior (back) teeth**

Complex or other Endodontic Services

- **Apexification** - For dependent children through the age of 16
- **Retrograde filling**
- **Hemisection, includes root removal**

LIMITATION: All of the above procedures are covered 1 time per tooth per lifetime.

EXCLUSIONS - Coverage is NOT provided for:

1. Retreatment of endodontic services that have been previously benefited under the Plan.
2. Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
3. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
4. Intentional reimplantation.

9.06 **COVERAGE B1c: Periodontics***

* IMPORTANT: Refer to Estimate of Benefits

Basic Non-Surgical Periodontal Care - Treatment for diseases for the gingival (gums) and bone supporting the teeth.

- **Periodontal scaling & root planing** - Covered 1 time per 24 months.
- **Full mouth debridement** - Covered 1 time per lifetime.

Complex Surgical Periodontal Care - Surgical treatment for diseases for the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this plan.

- **Gingivectomy/gingivoplasty**
- **Gingival flap**
- **Apically positioned flap**
- **Osseous surgery**
- **Bone replacement graft**
- **Pedicle soft tissue graft**
- **Free soft tissue graft**
- **Subepithelial connective tissue graft**
- **Soft tissue allograft**
- **Combined connective tissue and double pedicle graft**
- **Distal/proximal wedge**

LIMITATION: Only 1 complex surgical periodontal service is a benefit covered 1 time per 36-month period per single tooth or multiple teeth in the same quadrant.

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Bacteriologic tests for determination of periodontal disease or pathologic agents.
3. The controlled release of therapeutic agents or biologic materials used to aid in soft tissue and osseous tissue regeneration.
4. Provisional splinting, temporary procedures or interim stabilization of teeth.
5. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide or therapeutic drug injections, drugs, or medicaments for non-surgical and surgical periodontal care, regardless of the method of administration.

9.07 **COVERAGE B1d: Oral Surgery**

Basic Extractions

- Removal of Coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Other Complex Surgical Procedures

- Oroantral fistula closure
- Tooth reimplantation - accidentally evulsed or displaced tooth
- Surgical exposure of impacted or unerupted tooth to aid eruption

- Biopsy of oral tissue
- Transseptal fiberotomy
- Alveoloplasty
- Vestibuloplasty
- Excision of lesion or tumor
- Removal or nonodontogenic or odontogenic cyst or tumor
- Removal of exostosis
- Partial ostectomy
- Incision & drainage of abscess
- Frenulectomy (frenectomy or frenotomy)

Temporomandibular Joint Disorder (TMJ) as covered under Minnesota Statutes Section 62A.043 Subd. 3 -

Dental treatment that is considered surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder, including splints, is subject to the coordination of benefits. A Pre-treatment Estimate of Benefits is recommended.

NOTE: If you or your dependents currently have medical insurance coverage, the claim must first be submitted to that medical insurance program. Any remaining costs after consideration under your medical insurance may be submitted to the Plan for further benefit (see Coordination of Benefits). You must submit a copy of the medical Explanation of Benefits (EOB) along with your claim to this Plan.

If you or your dependents are not eligible for TMJ benefits under another insurance program, either medical or dental, dental services for TMJ will be covered under this dental Plan within the noted Plan limitations, maximums, deductibles and payment percentages of treatment costs.

LIMITATIONS

1. Reconstructive Surgery benefits shall be provided for reconstructive surgery when such dental procedures are incidental to or follows surgery resulting from injury, illness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, to the extent as required by Minnesota Statute 62A.25 provided, however, that such procedures are dental reconstructive surgical procedures.
2. Inpatient or outpatient dental expenses arising from dental treatment, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate as required by Minnesota Statute section 62A.042.

   For programs without orthodontic coverage: Dental orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit plan.

   For programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this plan shall be primary and the other policy or contract shall be secondary.

EXCLUSIONS - Coverage is NOT provided for:

1. Intravenous conscious sedation and IV sedation when performed with non-surgical dental care.
2. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration.

3. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
4. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
5. Surgical exposure of impacted or unerupted tooth for orthodontic reasons.
6. Surgical repositioning of teeth.
7. Inpatient or outpatient hospital expenses.
8. Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.

9.08 **COVERAGE B2: Major Restorative Services -** Special restorative procedures to restore lost tooth structure as a result of tooth decay or fracture.

Posterior (back) Teeth Composite (white) Resin Restorations

- If the posterior (back) tooth requires a restoration due to decay or fracture

Gold foil restorations - Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances. The patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

Inlays - Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION: If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

Onlays or Permanent Crowns - Covered 1 time per 5-year period per tooth.

Implant Crowns - See Prosthetic Services.

Crown Repair - Covered 1 time per 12-month period per tooth.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface - Covered 1 time per 5-year period when done in conjunction with covered services.

Canal prep & fitting of preformed dowel & post

Occlusal procedures including occlusal guard and adjustments - Covered Persons 19 and older.

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
3. Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
4. Placement or removal of sedative filling, base or liner used under a restoration.
5. Temporary, provisional or interim crown.

9.09 **COVERAGE C: Prosthetics - Dentures, Partials, and Bridges***

Reline, Rebase, Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) - Covered when:

- the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Adjustments - Covered 2 times per 12-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Removable Prosthetic Services (Dentures and Partials) - Covered 1 time per 5-year period:

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) - Covered 1 time per 5-year period:

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last 5 years;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Single Tooth Implant Body, Abutment and Crown - Covered 1 time per 5-year period for covered persons age 16 and over. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a Pretreatment Estimate be requested to estimate the amount of payment prior to beginning treatment.

Restorative cast post and core build-up, including pins and posts - Covered 1 time per 5-year period when done in conjunction with covered fixed prosthetic services.

EXCLUSIONS - Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Interim removable or fixed prosthetic appliances (dentures, partials or bridges)
3. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
4. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
5. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
6. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment

of teeth, periodontal splinting and gnathologic recordings.

7. Services or supplies that have the primary purpose of improving the appearance of your teeth.
8. Placement or removal of sedative filling, base or liner used under a restoration.
9. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
10. Coverage shall be limited to the least expensive professionally acceptable treatment.

9.10 **COVERAGE D: Orthodontics***

Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.

Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.

Comprehensive (complete) Treatment - Full treatment includes all records, appliances and visits.

Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.

Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.

Other Complex Surgical Procedures

- **Surgical exposure of impacted or unerupted tooth for orthodontic reasons**
- **Surgical repositioning of teeth**

LIMITATION: Treatment in progress (appliances placed prior to eligibility under this Plan) will be benefited on a pro-rated basis. The orthodontia lifetime maximum increase to $3,000 applies to new treatments starting on or after January 1, 2020.

EXCLUSIONS - Coverage is NOT provided for:

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service;
4. Retreatment and/or services for any treatment due to relapse;
5. Inpatient or outpatient hospital expenses; and
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments: Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. The Covered Person must have continuous eligibility under the Plan in order to receive ongoing orthodontic benefit payments.

Benefit payments are made in three equal amounts: (1) when treatment begins (appliances are installed), (2) at 12 months, and (3) when treatment is completed or until the lifetime maximum benefits are exhausted (see Benefit Maximums in this Plan Summary).

Before treatment begins, the treating dentist should submit a Pre-treatment Estimate. An Estimate of Benefits form will be sent to you and your dentist indicating the estimated plan payment amount. This form serves as a claim form when treatment begins.

When treatment begins, the dentist should submit the Estimate of Benefit form with the date of placement and their signature. After benefit and eligibility verification by the Plan, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be issued to you and your dentist.

This again will serve as the claim form to be submitted 12 months from the date of appliance placement, and when treatment is completed.

SECTION 10
Exclusions and Limitations

10.01 EXCLUSIONS: Coverage is NOT provided for:

a) Dental services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving Medical Assistance pursuant to Minnesota Statute Section 62A.045.

b) Dental services or health care services not specifically covered under the Group Dental Plan Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).

c) New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.

d) Dental services performed for elective or cosmetic purposes. NOTE: Dental services may be subject to pre-payment clinical review of dental records. If services are found to not be dentally necessary, we reserve the right to deny such services and the member is responsible for the full charge. Dental services are subject to post-payment clinical review of dental records. If services are found not to be dentally necessary, we reserve the right to collect any payment and the member is responsible for the full charge.

e) Dental services completed prior to the date the Covered Person became eligible for coverage.

f) Services of anesthesiologists.

g) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in their office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.

h) Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

i) Dental services performed other than by a licensed dentist, licensed physician, their employees.

j) Dental services, 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, realignment of teeth, periodontal splinting and gnathologic recordings.

k) Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.

l) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.

m) Orthodontic treatment services, unless specified in this Dental Benefit Plan Summary as a covered dental service benefit.

n) Case presentations, office visits and consultations.

o) Incomplete, interim or temporary services.

p) Athletic mouth guards, enamel microabrasion and odontoplasty.

q) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.

r) Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.

s) Bacteriologic tests.

t) Cytology sample collection.

u) Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.

v) Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).

w) Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).

x) The replacement of an existing partial denture with a bridge.

y) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.

z) Provisional splinting, temporary procedures or interim stabilization.

aa) Placement or removal of sedative filling, base or liner used under a restoration.

bb) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.

cc) Oral Hygiene Instructions.

dd) Amalgam or composite restorations placed for preventive or cosmetic purposes.

10.02 LIMITATIONS

A. Alternative **Treatment Plan**s:
In all cases in which there are alternative plans of treatment carrying different treatment costs, the decision as to which course of treatment to be followed shall be solely that of the patient and the **Dentist**, however, the benefits payable hereunder will be made only for the **Applicable Percentage** of the least costly, most commonly performed course of treatment, with the balance of the treatment cost remaining the responsibility of the patient.

B. Reconstructive surgery:
Notwithstanding any language within the **Contract** to the contrary, benefits shall be provided for reconstructive surgery when such 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 Child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician provided, however, that such services are determined by **Delta Dental** to be dental reconstructive surgical procedures, and, further, that the amount of benefits for such services shall be subject to the MMB selected level of benefits, **Deductibles** and **Maximum Benefits** specified in Section 1, Paragraph 1.02.

C. Newborn Infants:
Coverage for a newborn infant, covered as a dependent under the **Contract**, includes dental treatment for the management of birth defects known as cleft lip and cleft palate if orthodontic coverage is provided under the **Contract** under Section 1, Paragraph 1.02. Coverage for cleft lip and cleft palate, if applicable, is limited to dependent children up to the age of 23.

D. Other Limitations:
   a. The benefit for the repeat of any non-surgical periodontal treatment will be provided only after a two (2) year period has elapsed.
   b. The benefit for the repeat of any surgical periodontal treatment will be provided only after a three (3) year period has elapsed.
   c. TMJ services are often covered first by your medical plan. Any remaining costs may be submitted to **Delta Dental** for further benefit. Note: your medical plan may require pre-authorization and/or a doctor's referral in order to receive any coverage. Please review your medical plan Summary of Benefits for instructions.
   d. The benefit for the replacement of a crown and onlays will be provided only after a five (5) year period measured from the date on which the procedure was last paid by **Delta Dental**.
   e. The procedures to enable prosthetic or restorative services to be performed, such as crown lengthening, are not covered.
   f. An inlay is benefited as an amalgam for the same surfaces, an inlay may be benefited if no other alternative is acceptable. A written appeal is to be submitted with the need documented. See Section 10.02 (A) (**Alternate Treatment Plans**).
   g. None of the individual units of the bridge may have been benefited previously as a crown, onlay or cast restoration during the last five (5) year period. The fabrication of the bridge due to the loss of an existing permanent tooth does not set aside the five (5) year exclusion on crown, onlay or cast restorations.

SECTION 11
Claim and Appeal Procedures

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

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

Your appeal must include your name, your identification number, group number, claim number, and dentist's name as shown on the Explanation of Benefits. Send your appeal to:

Delta Dental of Minnesota
Attention: Appeals Unit
PO Box 30416
Lansing, MI 48909

You may submit written comments, documents, or other information in support of your appeal. You will

also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim (whether or not presented or available at the initial determination) and the initial determination will not be given any weight.

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

Authorized Representative

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

SECTION 12
Out-of-Network Dentists

12.01 Some **Dentists**, for varying reasons, do not choose to be Participating **Dentists** in the **State Dental Plan – Delta Dental**. The fact that a **Dentist** is or is not a Participating **Dentist** in the **State Dental Plan – Delta Dental** does not imply superiority over any other licensed **Dentist**. Nor does it indicate that the dental fees of other licensed **Dentists** will vary from those who are participants. Participating **Dentists** are those who have agreed to serve as participants in the **State Dental Plan – Delta Dental** or the **National Network – Delta Dental** and follow the rules and regulations of **Delta Dental**.

Delta Dental believes that patients should be offered as wide a choice of practitioners as possible. Because the non-participant does not agree to abide by the rules and regulations of **Delta Dental**, no payments are made to such non-participating **Dentists** for benefits allowed under the **Contract**.

THE PATIENT IS RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY THE NON-PARTICIPATING **DENTIST**, and, upon treatment by a non-participating **Dentist**, **Delta Dental** will pay the allowable benefits under this **Contract** to the patient directly, unless benefits are authorized by the patient to be paid directly to the provider and required by applicable state law. These payments will be based on the amount established solely by **Delta Dental** or on the treating **Dentist**'s fees, whichever is less.

It is the policy of **Delta Dental** to treat all persons alike, without distinctions based on race, color, religion, national origin, disability, sex or age. If you have questions about this policy, contact Customer Service at (651) 406-5916 or 1-800-553-9536. Hearing impaired members with a TDD phone may contact Customer Service at (651) 406-5923 or 1-888-853-7570. If you have an impairment that requires alternative communication formats such as Braille, large print or audio cassettes, please request these materials from Customer Service at the phone numbers listed above. If this Summary of Benefits is provided in one of these alternative communication formats, this written version governs all coverage decisions.

DELTA DENTAL OF MINNESOTA

FOR CLAIMS AND ELIGIBILITY
PO Box 9120
Farmington Hills, MI 48333-9120
(651) 406-5916 or (800) 553-9536

FOR APPEALS
PO Box 30416
Lansing, MI 48909

CORPORATE LOCATION
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