



DELTA DENTAL OF MINNESOTA

Delta Dental PPO

GROUP #6100

NARROW NETWORK PLAN

Using the Delta Dental PPO Network



DENTAL BENEFIT PLAN SUMMARY

Specific Information About the Plan

Employer:	University of Minnesota
Name of the Plan:	The plan shall be known as the University of Minnesota UPlan Dental Program, which provides dental benefits to certain eligible participants and their dependents.
Address of the Plan:	University of Minnesota Employee Benefits 100 Donhowe Building 319 15 th Avenue SE Minneapolis, MN 55455-0103
Plan Year:	The Plan Year begins on January 1 and ends on December 31. A Plan Year is 12 months in duration.
Plan Sponsor:	Board of Regents 600 McNamara Alumni Center 200 Oak Street SE Minneapolis, MN 55455-2020
Funding:	Claims under the Plan are paid from employer and employee contributions to the University of Minnesota UPlan Dental Program.
Claim Administrator:	Delta Dental Plan of Minnesota Mailing Address: P.O. Box 330 Minneapolis, MN 55440-0330

UNIVERSITY OF MINNESOTA HEALTH PLANS NOTICE OF PRIVACY PRACTICES

EFFECTIVE APRIL 14, 2003 (AMENDED JANUARY 1, 2004 TO INCLUDE DENTAL COVERAGE)

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

University of Minnesota-Sponsored Health Plans Covered by this Notice

This notice describes the practices of the following group health plans (collectively, the "Plan") and will apply to you to the extent you participate in these plans. If you participate in other plans, you may receive additional notices.

- UPlan Medical Benefit
- UPlan Prescription Drug Benefit
- UPlan Dental Benefit
- Emergency Medical Assistance Program
- Health Care Flexible Spending Account
- Employee Assistance Program
- UPlan Wellness Program

These group health plans are part of an organized health care arrangement and may share protected health information for the treatment, payment and health care operations purposes described.

Pledge Regarding Your Protected Health Information

This notice explains how the Plan uses and discloses your protected health information and the rights that you have with respect to accessing that information and keeping it confidential. "Protected health information" means information that individually identifies you, and relates to payment for your health care, your health or condition, or health care you receive, including demographic information. The Plan creates, receives and maintains eligibility and enrollment information, information about your health care claims paid under the Plan, and other protected health information that is necessary to administer the Plan.

The Plan is required by law to maintain the privacy of your protected health information and to provide this notice to you. This notice explains the Plan's legal duties and privacy practices, and your rights regarding your protected health information. The Plan is committed to protecting the privacy of your protected health information by complying with all applicable federal and state laws.

While this notice is in effect, the Plan must follow the privacy practices described. This notice takes effect on the date shown at the top of this section, and will remain in effect until it is replaced. 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 reserves the right to make such changes effective for all protected health information that the Plan maintains, including information created or received before the changes were made.

You may request a copy of the Plan's privacy notice at any time. For more information about the Plan's privacy practices, or for additional copies of this notice, please contact the Plan using the information listed at the end of this notice.

Uses and Disclosures of Your Protected Health Information

The following categories describe the different ways that the Plan uses and discloses your protected health information. Not every use or disclosure within a category is listed, but all uses and disclosures fall into one of the following categories.

Payment

The Plan may use and disclose protected health information about you for payment purposes, such as determining your eligibility for Plan benefits, facilitating payment for treatment and health care services you receive, determining benefit responsibility under the Plan, coordinating benefits with other Plans, determining medical necessity, and so on. For example, the Plan may share protected health information with third party administrators hired to provide claims services and other administrative services to the Plan.

Health Care Operations

The Plan may use and disclose protected health information about you for health care operations. These uses and disclosures are necessary to operate the Plan. For example, the Plan uses and discloses protected health information to conduct quality assessment and improvement activities, and for cost management and business management purposes.

Treatment

The Plan may use or disclose protected health information for treatment purposes, including helping providers to coordinate your care. Only the minimum amount of information necessary will be disclosed. For example, an emergency care provider may contact the Plan to find out what other providers you use, so that he or she can contact them to get medical records necessary to your care, if you are unable to provide that information.

Disclosures to the Plan Sponsor

The Plan may disclose your protected health information to the University of Minnesota, which sponsors the Plan, but only to permit the University to perform Plan administration functions. These disclosures may be made only to the administrative units of the University, primarily the Benefits Department, involved in Plan administration, and will be strictly limited to disclosures necessary for Plan administration purposes.

Disclosures to Other Plans

Each plan sponsored by the University of Minnesota may disclose your protected health information to another health plan sponsored by the University of Minnesota to facilitate claims payment and certain health care operations of the other plan.

Uses and Disclosures You Specifically Authorize

You may give the Plan written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give the Plan an authorization, you may revoke it in writing at any time. If you revoke your permission, the Plan will stop using or disclosing your protected health information in accordance with that authorization, except to the extent the Plan has already relied on it. Without your written authorization, the Plan may not use or disclose your protected health information for any reason except those described in this notice.

Plan Communications with Individuals Involved in Your Care (or Payment for Your Care):

In general, the Plan will communicate directly with you about your claims and other Plan-related matters that involve your protected health information. In some cases, however, it may be appropriate to communicate about these matters with other individuals involved in your health care or payment for that care, such as your family, relatives, or close personal friends (or anyone else, if you choose to designate them).

If you agree, the Plan may disclose to these persons protected health information about you that is directly relevant to their involvement in these matters. The Plan may also make such disclosures to these persons if you are given the opportunity to object to the disclosures and do not do so, or if the Plan reasonably infers

from the circumstances that you do not object to disclosure to these persons. The Plan would not need to obtain your written authorization. For example, if you are an employee and are attempting to resolve a claims dispute with the Plan, and you orally inform the Plan that your spouse will be calling the Plan for additional discussion of these issues, the Plan would be permitted to disclose protected health information directly relevant to that dispute to your spouse.

The Plan also may 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 protected health information to persons involved in your care (or payment) if it determines that the disclosure is in your best interest.

Communication about Benefits, Products, and Services

The Plan may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives, or to tell you about health-related products or services (or payment or coverage for such products or services) that may be of interest to you. The Plan may use your protected health information to contact you with information about benefits under the Plan, including certain communications about health plan networks, health plan changes, and value-added health plan-related products or services. The Plan may communicate with you face-to-face regarding any benefits, products or services. The Plan may use or disclose protected health information to distribute small promotional gifts.

Required by Law

The Plan may use or disclose your protected health information when required to do so by law. For example disclosures to the Secretary of Health & Human Services for the purpose of determining the Plan's compliance with federal privacy law.

Disaster Relief

The Plan may use or disclose your name, location and general condition (or death) to a public or private organization authorized to assist in disaster relief efforts.

Public Health and Safety

The Plan may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others (but only to someone in a position to help prevent the threat). The Plan may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes. The Plan may disclose your protected health information to appropriate authorities if it reasonably believes that you are a possible victim of abuse, neglect, domestic violence or other crimes.

Lawsuits and Disputes

The Plan may disclose your protected health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, in accordance with specified procedural safeguards.

Law Enforcement

Under circumstances, such as a court order, or court-issued warrant, subpoena or summons, or grand jury subpoena, the Plan may disclose your protected health information to law enforcement officials. The Plan also may disclose limited protected health information to a law enforcement official concerning a suspect, fugitive, material witness, crime victim or missing person. The Plan may disclose protected health information about the victim of a crime (under limited circumstances); about a death the Plan believes may be the result of criminal conduct; to report a crime on the premises of the Plan; or, in an emergency, information relating to a crime not on the premises. If you are an inmate of a correctional institution, the Plan may disclose protected health information to the institution or to law enforcement.

Research

The Plan may use or disclose protected health information 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.

Decedents (Death, Organ/Tissue Donation)

The Plan may disclose the protected health information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization, for certain limited purposes.

Military and National Security

The Plan may disclose to military authorities the protected health information of armed forces personnel under certain circumstances. The Plan may disclose to authorized federal officials protected health information required for intelligence, counter-intelligence, and other national security activities authorized by law.

Workers' Compensation

The Plan may disclose protected health information about you for workers' compensation or similar programs established by law to provide benefits for work-related injuries or illness.

De-Identified Data

The Plan may create a collection of information that can no longer be traced back to you (i.e., does not contain individually identifying information).

Your Rights**Access**

You have the right to look at or get copies of protected health information maintained by the Plan that may be used to make decisions about your Plan eligibility and benefits, with limited exceptions. The Plan reserves the right to require you to make this request in writing. If you request copies, you may be charged a fee to cover the costs of copying, mailing and other supplies. If you prefer, the Plan will prepare a summary or an explanation of your protected health information for a fee.

To request access and/or a full explanation of the fee structure under the UPlan, contact the Claims Administrator at the Member Services phone number on your medical, prescription drug, or dental ID card. For the Emergency Medical Assistance Program, Health Care Flexible Spending Account, Employee Assistance Program, or UPlan Wellness Program, contact the Benefits Service Center at the number shown at the end of this notice.

The Plan may deny your request in very limited circumstances. If the Plan denies your request, you may be entitled to a review of that denial. You will be told how to obtain a review. The Plan will abide by the outcome of that review.

Amendment

If you feel that your protected health information is incorrect or incomplete, you have the right to request that the Plan amend it. The Plan reserves the right to require this request be in writing, including a reason to support your request. To submit a request under the UPlan, contact the Claims Administrator at the Member Services phone number on your medical, prescription drug, or dental ID card. For the Emergency Medical Assistance Program, Health Care Flexible Spending Account, Employee Assistance Program, or UPlan Wellness Program, contact the Benefits Service Center at the number shown at the end of this notice.

The Plan may deny your request if the Plan did not create the information you want amended or for certain other reasons. If the Plan denies your request, the Plan will provide you a written explanation and the process to be followed for any additional action.

Accounting of Disclosures

You have the right to receive a list of disclosures the Plan has made of your protected health information. This right does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. Your request for the accounting must be in writing.

To request an accounting under the UPlan, contact the Claims Administrator at the Member Services phone number on your medical, prescription drug, or dental ID card. For the Emergency Medical Assistance Program, Health Care Flexible Spending Account, Employee Assistance Program, or UPlan Wellness Program, contact the Benefits Service Center at the number shown at the end of this notice.

You are entitled to such an accounting for the six (6) years prior to your request, though not earlier than April 14, 2003. The Plan will provide you with the date on which it made a disclosure, the name of the person or entity to whom it disclosed your protected health information, a description of the protected health information it disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, the Plan may charge you a reasonable, cost-based fee for responding to these additional requests. You will be notified of the cost involved and be given the opportunity to withdraw or change your request before any costs are incurred.

Restriction Requests

You have the right to request that the Plan place additional restrictions on its use or disclosure of your protected health information for treatment, payment, or health care operations. The Plan is not required to agree to these restrictions, but if it does, the Plan will abide by its agreement except in an emergency). Any such agreement by the Plan must be in writing signed by a person authorized to make such an agreement on our behalf; without this written agreement, the Plan will not be bound by the requested restrictions. Please use the contact information at the end of this notice to get more information about how to make such a request.

Confidential Communication

You have the right to request that the Plan communicate with you about your protected health information by alternative means or to an alternative location. For example, you may ask that the Plan contact you only at work or by mail. You must make your request in writing and must specify how or where you wish to be contacted. Your request must state that the information could endanger you if it is not communicated in confidence as you request. The Plan will accommodate all reasonable requests. Please use the contact information at the end of this notice to get more information about how to make such a request.

Copy of this Notice

You are entitled to receive a printed (paper) copy of this notice at any time. Please contact the Plan using the information listed at the end of this notice to obtain a copy of this notice in printed form.

Questions and Complaints

If you want more information about the Plan's privacy practices, have questions or concerns, or believe that the Plan may have violated your privacy rights, please contact the Plan using the following information:

Benefits Service Center
800-756-2363 (option 2)
612-624-9090 (option 2)

You also may submit a written complaint to the U.S. Department of Health and Human Services. The Plan will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

The Plan supports your right to protect the privacy of your health information. The Plan will not retaliate in any way if you choose to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

DENTAL BENEFIT PLAN SUMMARY

This is a Summary of your Group Dental Program
(PROGRAM) prepared for Covered Persons with:

University of Minnesota
(GROUP)

This Program has been established and is maintained and administered in accordance with the provisions of your Group Dental Plan Contract Number **6100** issued by Delta Dental of Minnesota **(PLAN)**.

IMPORTANT

This booklet is subject to the provisions of the Group Dental Agreement and cannot modify this agreement in any way; nor shall you accrue any rights because of any statement in or omission from this booklet.

DELTA DENTAL OF MINNESOTA

Administrative Offices

P.O. Box 330

Minneapolis, Minnesota 55440-0330

(651) 406-5916 or (800) 553-9536

www.deltadentalmn.org

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BASICS TO UTILIZING YOUR DENTAL PROGRAM

How to Find a Participating Dentist

A real-time listing of participating dentists is available in an interactive directory at the Plan's user friendly web site, www.deltadentalmn.org. The Plan highly recommends use of the web site for the most accurate network information. Go to <http://www.deltadentalmn.org/dentist/search.asp> and enter your zip code, city or state to find local participating dentists. You can also search by dentist or clinic name. The Web site also allows you to print out a map directing you to the dental office you select. **The Dentist Search is an accurate and up-to-date way to obtain information on participating dentists.**

To search for and verify the status of participating providers, select "Dentist Search" on the www.deltadentalmn.org home page. Select the Product or Network in the drop-down menu, and search by city and state, zip code or provider or clinic name. If your dentist does not participate in the network, you may continue to use that dentist, although you will share more of the cost of your care and could be responsible for dental charges up to the dentist's full billed amount.

If you do not have Internet access, other options are available to find a network dentist or verify that your current dentist is in the network.

- When you call to make a dental appointment, always verify the dentist is a participating dentist. **Be sure to specifically state that your employer is providing the Dental program.**
- Contact our Customer Service Center at: (651) 406-5916 or (800) 553-9536. Customer Service hours are 7 a.m. to 7 p.m., Monday through Friday, Central Standard Time.

Using Your Dental Program

Dentists who participate with Delta under this Program are independent contractors. The relationship between you and the participating dentist you select to provide your dental services is strictly that of provider and patient. Delta cannot and does not make any representations as to the quality of treatment outcomes of individual dentists, nor recommends that a particular dentist be consulted for professional care.

All claims should be submitted within 12 months of the date of service.

If your dentist is a participating dentist, the claim form will be available at the dentist's office.

If your dentist is nonparticipating, claim forms are available by calling:

Delta Dental of Minnesota - (651) 406-5916 or (800) 553-9536

The Plan also accepts the standard American Dental Association (ADA) claim form used by most dentists.

The dental office will file the claim form with the Plan; however, you may be required to assist in completing the patient information portion on the form (Items 1 through 14).

During your first dental appointment, it is very important to advise your dentist of the following information:

- * YOUR DELTA GROUP NUMBER
- * YOUR EMPLOYER (GROUP NAME)

- * YOUR IDENTIFICATION NUMBER (your dependents must use **YOUR** Identification number)
- * YOUR BIRTHDAY AND THE BIRTH DATES OF YOUR SPOUSE AND DEPENDENT CHILDREN

Participating Dentist Network

A Delta Dental PPO network dentist is a dentist who has signed a Delta Dental PPO agreement with Delta Dental of Minnesota. The dentist has agreed to accept the Delta Dental PPO Maximum Amount Payable as payment in full for covered dental care. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental PPO dentist has agreed not to bill more than the Delta Dental PPO Maximum Amount Payable. A Delta Dental PPO dentist has also agreed to file the claim directly with Delta Dental.

You must see a Delta Dental PPO provider dentist in order to receive benefits under this Plan.

SUMMARY OF DENTAL BENEFITS

After you have satisfied the deductible, if any, your dental program pays the following percentages of the treatment cost, up to a maximum fee per procedure.

	<u>Delta Dental PPO</u>
Diagnostic and Preventive Service	100%
Basic Services	80%
Endodontic Services	80%
Periodontics	80%
Oral Surgery	80%
Complex or Major Restorative Services	80%
Prosthetic Services	50%
Prosthetic Repairs and Adjustments.....	50%
Orthodontics	80%

NOTE: Out of Network Services will be paid at 0% except for emergency services. Emergency Services will be allowed out of network after a \$50 deductible per person. The emergency services will be paid the same as the Delta Dental PPO Network percentage.

Benefit Maximums

The Program pays up to a maximum of \$1,500.00 for each Covered Person per Coverage Year subject to the coverage percentages identified above. Benefit Maximums may not be carried over to future coverage years.

Orthodontics is subject to a separate lifetime maximum of \$2,800.00 per Covered Person and limited to those orthodontic treatment plans commenced prior to the Covered Dependent Child's nineteenth (19th) birthday. Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. The Covered Person must remain eligible under the Plan in order to receive continued benefit payments.

Deductible

There is no deductible applied to dental services from a Delta Dental PPO network provider.

Coverage Year

A Coverage Year is a 12-month period in which deductibles and benefit maximums apply. Your Coverage Year is January 1 to December 31.

DESCRIPTION OF COVERED PROCEDURES

Pretreatment Estimate

(Estimate of Benefits)

IT IS RECOMMENDED THAT A PRETREATMENT ESTIMATE BE SUBMITTED TO THE PLAN PRIOR TO TREATMENT IF YOUR DENTAL TREATMENT INVOLVES MAJOR RESTORATIVE, PERIODONTICS, PROSTHETIC OR ORTHODONTIC CARE (SEE DESCRIPTION OF COVERAGES), TO ESTIMATE THE AMOUNT OF PAYMENT. THE PRETREATMENT ESTIMATE IS A VALUABLE TOOL FOR BOTH THE DENTIST AND THE PATIENT. SUBMISSION OF A PRETREATMENT ESTIMATE ALLOWS THE DENTIST AND THE PATIENT TO KNOW WHAT BENEFITS ARE AVAILABLE TO THE PATIENT BEFORE BEGINNING TREATMENT. THE 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. THIS PROCESS DOES NOT PRIOR AUTHORIZE THE TREATMENT NOR DETERMINE ITS DENTAL OR MEDICAL NECESSITY. THE ESTIMATED DELTA DENTAL PAYMENT IS BASED ON THE PATIENT'S CURRENT ELIGIBILITY AND CURRENT AVAILABLE CONTRACT BENEFITS. THE SUBSEQUENT SUBMISSION OF OTHER CLAIMS, A CHANGE IN ELIGIBILITY, A CHANGE IN THE CONTRACT COVERAGE OR THE EXISTENCE OF OTHER COVERAGE MAY ALTER THE DELTA DENTAL FINAL PAYMENT AMOUNT AS SHOWN ON THE PRETREATMENT ESTIMATE FORM.

After the examination, your dentist will establish the dental treatment to be performed. If the dental treatment necessary involves major restorative, periodontic, prosthetic or orthodontic care, a participating dentist should submit a claim form to the Plan outlining the proposed treatment.

A Pretreatment Estimate of Benefits statement will be sent to you and your dentist. You will be responsible for payment of any deductibles and coinsurance amounts or any dental treatment that is not considered a covered service under the Plan.

Benefits

The Program covers the following dental procedures when they are performed by a licensed dentist and when necessary and customary as determined by the standards of generally accepted dental practice. The benefits under this Program shall be provided whether the dental procedures are performed by a duly licensed physician or a duly licensed dentist, if otherwise covered under this Program, provided that such dental procedures can be lawfully performed within the scope of a duly licensed dentist.

As a condition precedent to the approval of claim payments, the Plan 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 a dentist's care is provided, such information and records relating to a Covered Person as may be required to pay claims. Also, the Plan may require that a Covered Person be examined by a dental consultant retained by the Plan in or near the Covered Person's place of residence. The Plan shall hold such information and records confidential.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN THE DELTA DENTAL PPO NETWORK PRIOR TO RECEIVING DENTAL CARE.

Delta Dental of Minnesota does not determine whether a service submitted for payment or benefit under this Plan is a dental procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. Delta Dental of Minnesota evaluates dental procedures submitted to determine if the procedure is a covered benefit under your dental plan. Your dental Plan includes a preset schedule of dental services that are eligible for benefit by the Plan. Other dental services may be recommended or prescribed by your dentist which are dentally necessary, offer you an enhanced cosmetic appearance, or are more frequent than covered by the Plan. While these services may be prescribed by your dentist and are dentally necessary for you, they may not be a dental service that is benefited by this Plan or they may be a service where the Plan provides a payment allowance for a service that is considered to be optional treatment. If the Plan gives you a payment allowance for optional treatment that is covered by the plan, you may apply this Plan payment to the service prescribed by your dentist which you elected to receive. Services that are not covered by the Plan or exceed the frequency of Plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for dental services that are not covered or benefited by the Plan. Determination of services necessary to meet your individual dental needs is between you and your dentist.

ONLY those services listed are covered. Deductibles and maximums are listed under the Summary of Dental Benefits. Services covered are subject to the limitations within the Benefits, Exclusions and Limitations sections described below. For estimates of covered services, please see the "Pretreatment Estimate" section of this booklet.

PREVENTIVE CARE (Diagnostic & Preventive Services)

Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

NOTE: Comprehensive oral evaluations will be benefited 1 time per dental office, subject to the 2 times per calendar 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 2 times per calendar year.

Limited oral evaluation - problem focused (emergency exams) are covered 1 time per calendar year and are separate from all other oral exams.

Radiographs (X-rays)

- **Bitewings** – Covered at 1 series of bitewings per 12-month period.
- **Full Mouth (Complete Series) or Panoramic** – Covered 1 time per 3 year period.
- **Periapical(s)** - single X-rays
- **Occlusal** - Covered at 1 series per 12-month period.

Dental Cleaning shall be benefited as follows:

- Two (2) dental prophylaxis per calendar year;
- An additional two (2) periodontal maintenance (prophylaxis) per calendar year; OR
- A total of four (4) periodontal maintenance (prophylaxis) per calendar 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 (Prophylaxis) 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.

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.

EXCLUSIONS - Coverage is NOT provided for:

1. Oral Hygiene Instructions.
2. Fluoride Treatment is not covered for adults and/or dependents over age of 19.

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** - Treatment to restore decayed or fractured permanent or primary posterior (back) teeth. Benefits shall be limited to the same surfaces and allowances for amalgam (silver filling). 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.

LIMITATION: Coverage for amalgam or composite restorations will be limited to only 1 service per tooth surface per 24-month period.

Other Basic Services

- **Pre-fabricated or Stainless Steel Crown** - Covered 1 time per 24-month period for eligible dependent children through the age of 18.
- **Sealants** - Covered 1 time per lifetime for permanent first and second molars of eligible dependent children through the age of 18.
- **Restorative cast post and core build-up, including pins and posts** - See benefit coverage description under Complex or Major Restorative Services.

Adjunctive General Services

- **Intravenous Conscious Sedation and IV Sedation** - Covered when performed in conjunction with covered oral surgery services.
- **General Anesthesia, analgesia or nitrous oxide** -- covered when performed in conjunction with covered oral surgery services.

EXCLUSIONS - Coverage is NOT provided for:

1. Case presentation and office visits.
2. Athletic mouthguard, enamel microabrasion, and odontoplasty.
3. 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.
4. Placement or removal of sedative filling, base or liner used under a restoration.

ENDODONTIC SERVICES (NERVE OR PULP TREATMENT)

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 2 years.

EXCLUSIONS - Coverage is NOT provided for:

1. Retreatment of endodontic services that have been previously benefited under the Plan, unless otherwise specified.
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.

PERIODONTICS (GUM & BONE TREATMENT)

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 2 years.
- **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 curettage**
- **Gingival flap**
- **Apically positioned flap**
- **Mucogingival surgery**
- **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 3 year 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. Medicines or drugs for non-surgical or surgical dental care, regardless of the method of administration. Note: Antibiotics administered by the dental provider in the dental office will be covered.

ORAL SURGERY (TOOTH, TISSUE, OR BONE REMOVAL)

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 of 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 up to age 18, 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. Non-Intravenous conscious sedation.
2. Medicines or drugs for non-surgical or surgical dental care, regardless of the method of administration. Note: Antibiotics administered by the dental provider in the dental office will be covered.
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.

COMPLEX OR MAJOR RESTORATIVE SERVICES

Services performed to restore lost tooth structure as a result of decay or fracture

Gold foil restorations - Benefit shall equal an amalgam (silver) restoration for the same number of surfaces. 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. All covered implant related services will be benefited under the Prosthetics Services benefit.

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 complex or major restorative services.

Canal prep & fitting of preformed dowel & post.

Occlusal procedures including occlusal guard and adjustments – Through the age of 18.

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.

PROSTHETIC SERVICES (DENTURES, PARTIALS, BRIDGES AND IMPLANTS)

Removable Prosthetic Services (Dentures and Partial) - 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.

Implants (Single Tooth Implant Body, Abutment and Crown)

- Covered 1 time per 5-year period for covered persons age 16 and older. 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 you send in a pretreatment estimate, so you know what is covered 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.

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).

EXCLUSIONS - Coverage is NOT provided for:

1. Coverage is not provided for the replacement of misplaced, lost or stolen dental prosthetic appliances.
2. The replacement of an existing partial denture with a bridge.
3. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
4. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
5. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
6. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
7. 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.
8. Services or supplies that have the primary purpose of improving the appearance of your teeth.
9. Placement or removal of sedative filling, base or liner used under a restoration.
10. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
11. Coverage shall be limited to the least expensive professionally acceptable treatment.

ORTHODONTICS

Treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies on covered eligible dependent children through the age of 18.

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: Covered eligible dependent children through the age of 18.

LIMITATION: Treatment in progress (appliances placed prior to eligibility under this Plan) will be benefited on a pro-rated basis.

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 equal amounts: (1) when treatment begins (appliances are installed), (2) at twelve month intervals thereafter, and (3) upon band removal at treatment completion or until the lifetime maximum benefits are exhausted (see Benefit Maximums in this Plan Summary).

The Plan pays up to the orthodontic maximum, less the total amount of any benefit received for orthodontic treatment under any UPlan or other University of Minnesota dental coverage, which was previously in force. It is the covered persons' responsibility to provide documentation of benefits received under prior UPlan or University of Minnesota dental coverage.

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 his/her 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 6 months from the date of appliance placement.

General 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 cosmetic purposes. NOTE: Dental services are subject to post-payment review of dental records. If services are found to be cosmetic, 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 his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.
- h) Medicines or drugs for non-surgical or surgical dental care, regardless of the method of administration. Note: Antibiotics administered by the dental provider in the dental office will be covered.
- i) Dental services performed other than by a licensed dentist, licensed physician, his or her 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, tooth bonding or 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) Fluoride Treatment is not covered for adults and/or dependents over age of 19.
- ee) Coverage is not provided for the replacement of misplaced, lost or stolen dental prosthetic appliances.

General Limitations

- a) **Optional Treatment Plans:** in all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Person and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.
- b) **Reconstructive Surgery:** benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from injury, sickness 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 MN Statute 62A.25 provided, however, that such services are dental reconstructive surgical services.
- c) **Benefits for inpatient or outpatient expenses arising from dental services up to age 18, including orthodontic and oral surgery services, involved in the management of birth defects known as cleft lip and cleft palate as required by Minnesota Statutes Section 62A.042.** For Programs without orthodontic coverage: Dental orthodontic services not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit program. 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.

For other dental procedure exclusions and limitations, refer to the Description of Coverage in this Dental Benefit Plan Summary.

Post Payment Review

Dental services are evaluated after treatment is rendered for accuracy of payment, benefit coverage and potential fraud or abuse as defined in the Health Insurance Portability and Accountability Act of 1996 - Public Law 102-191. Any payments for dental services completed solely for cosmetic purposes or payments for services not performed as billed are subject to recovery. Delta Dental's right to conduct post payment review and its right of recovery exists even if a Pretreatment Estimate was submitted for the service.

Optional Treatment Plans

In all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Person and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.

ELIGIBILITY

The University of Minnesota develops eligibility criteria for its employees and their dependents subject to collective bargaining agreements and compensation plans that may change during a Plan Year. An employee is eligible to participate in the University of Minnesota UPlan Medical and/or Dental Program (the Plan) if he/she is working at the University with an appointment of at least 50 percent time and lasting at least three months in duration. The University contributes a significant portion of the cost of medical and/or dental benefits for an employee with an appointment of 75 percent time or greater. If the employee's appointment is at least 50 percent to 74 percent time, the employee is eligible to participate in the Plan but must pay full cost of coverage; there is no University contribution at this level of employment.

In no event can a person receive coverage as both an employee and as a dependent of another Plan member. For example, you may not have coverage for yourself as an employee and be a dependent on the coverage of a spouse/registered same-sex domestic partner or a parent who has family coverage as a University of Minnesota employee.

In no event can an employee include a dependent on the Plan who is ineligible for coverage. The Plan reserves the right to request documentation to verify eligibility of your enrolled dependents.

1. Definition of Eligible Dependents

The individuals listed on the chart on the following page are considered eligible dependents for the Plan. In addition to specifying criteria for coverage, the chart also includes information as to whether the dependent is considered qualified for favorable tax treatment under the Plan.

Individuals Eligible as Dependents under the UPlan Medical and Dental Program

Relationship to Employee	Criteria for Coverage	Is Dependent Qualified for Tax Favored Treatment ⁽¹⁾
Spouse	<p>Must be legally married.</p> <p>Your spouse must not be working full-time for an employer and receiving cash or credits 1) in place of medical coverage or 2) in exchange for medical coverage with a deductible of \$750 or greater.</p>	Qualified
Same-Sex Domestic Partner	<p>Must be registered as same-sex domestic partner.</p> <p>Your registered same-sex domestic partner must not be working full-time for an employer and receiving cash or credits 1) in place of medical coverage or 2) in exchange for medical coverage with a deductible of \$750 or greater.</p>	Usually non-qualified. Refer to same-sex domestic partner Information in this definition of eligibility

<p>Unmarried Dependent Child</p> <p>To be considered a Dependent Child under the Plan, the child may meet any one of the criteria for Unmarried Dependent Child coverage listed in the middle column of this chart.</p> <p>A child can include your biological child, legally adopted child or child placed for the purposes of adoption, foster child, stepchild, or any other child state or federal law requires be treated as a dependent. A child can also include an eligible child of your registered same-sex domestic partner.</p>	<p>Dependent child — birth through end of year that child turns age 18</p>	Qualified
	<p>Child who is 50% dependent on employee — regardless of student status</p> <p>Dependent child through age 24 if more than 50% dependent on you (the employee), regardless of the dependent's student status</p>	Qualified, with special rules for children who are living with a relative other than the parent
	<p>Child who is a full-time student</p> <p>1. Full-time student up to but not including the year in which he/she turns age 24, and 2. does not provide over half of his/her <i>own</i> support, and 3. maintains legal residence with you</p>	Qualified
	<p>Disabled child</p> <p>Age 18 or above (no maximum) if physically or mentally disabled and either:</p> <ul style="list-style-type: none"> • lives with you and does not provide over 50% of his/her own support, or • does not live with you but is at least 50% dependent on you <p>For disabled children over age 24, see additional information in this definition.</p>	Qualified
	<p>Child not meeting any of above criteria</p> <p>Other child through age 24 not meeting any of the above criteria</p>	Non-Qualified
	<p>Child of registered same-sex domestic partner</p> <p>Child of registered same-sex domestic partner from birth through age 24</p>	Usually non-qualified. Refer to same-sex domestic partner Information in this definition of eligibility.

(1) "Tax Favored Treatment" refers to how dependent coverage is treated for tax purposes.

2. Tax Favored and Non-Tax Favored Treatment of Dependent Coverage

If the right-hand column above is marked "Qualified" for a given dependent category, it means you will pay pre-tax contributions for yourself and any dependents. It also means that the value of the University's contribution to the plan is not considered taxable income to you as the employee.

There are special rules for shared custody situations. Please refer to IRS Publication 501 or to the details of your divorce or separation agreement.

If you are providing over one-half of a child's support for a child who is living with a grandparent, sibling, aunt or uncle, the child is eligible for coverage under the Plan. However, the child is considered the dependent of the custodial individual under IRS rules, and is not eligible for tax favored coverage under the Plan.

If the right-hand column above is marked "Non-qualified" for a given dependent category, it means that you will have additional income, called imputed income, added to your paycheck for the coverage of the non-qualified dependent.

You will also pay the normal pre-tax employee contribution to cover yourself and any other family members. The value of the University's contribution for you and your tax qualified dependents is not considered taxable income to you as the employee.

It your responsibility as the employee to determine whether a dependent is considered to be a qualified or non-qualified dependent for purposes of determining whether coverage is tax favored under the Plan, and to enroll his/her dependent in the correct manner. Notice of any change in dependent tax status must be communicated to the University within 30 days of the change.

There are special rules about taxation of coverage for "Non-qualified" dependents that apply in limited circumstances:

When a part time employee pays the full cost of coverage on a pre-tax basis, the cost of coverage for the "Non-qualified" dependent would still be considered imputed income for the employee because the coverage is otherwise being paid on a pre-tax basis.

When an early retiree or disabled participant pays the full cost of coverage on an after-tax basis, and has a "Non-qualified" dependent child, there is no additional taxable income requirement because the plan member is already paying the full cost of coverage.

When a former employee pays a portion of the cost of coverage on an after-tax basis, and has a "Non-qualified dependent child, the cost of coverage for the child in excess of the after-tax payment would be taxable to the former employee. This amount would be reported on a W-2 form.

3. Eligible Dependent Children

- a) An eligible child can include your own biological child, legally adopted child or child placed for the purposes of adoption, foster child, stepchild, and any other child state or federal law requires be treated as a dependent. Eligible child can also include the child of your registered same-sex domestic partner, although that coverage is generally not available on a tax favored status.
 - i) The date of placement for a child who is being adopted means the assumption and retention by a person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support.
 - ii) To be considered a dependent child, a foster child must be dependent on you for his/her principal support and maintenance, and must be placed by the court in your custody.
 - iii) To be considered a dependent child, a stepchild must be dependent on you for his/her principal support and maintenance and must not be a dependent child for tax purposes of any other individual. A stepchild means the child of your spouse by a previous marriage/partnership.

"Principal support" means more than half of the dependent child's support.

- b) The child of your same-sex domestic partner can be considered a dependent child if your same-sex domestic partner is registered with the University and the child meets all other requirements for an eligible child. This applies to both the children of your registered same-sex domestic partner from your current partnership or his/her previous marriage/partnership.

- c) If both you and your spouse/registered same-sex domestic partner work for the University of Minnesota, then either of you, but not both, may cover your eligible dependent children/grandchildren. This also applies to two divorced, legally separated, or unmarried employees who share legal responsibility for their dependent children or grandchildren.
- d) Your dependent grandchild is eligible as a child if the grandchild is placed in your legal custody; legally adopted or placed with you for the purpose of adoption; or is the dependent child of your unmarried eligible child. The grandchild must be dependent upon you for more than one-half of his/her support.

4. Eligibility of Spouse/Registered Same-sex Domestic Partner

If both you and your spouse/registered same-sex domestic partner work for the University of Minnesota, then either of you has the option of adding the other as a dependent to his/her family coverage. The spouse/registered same-sex domestic partner added to the family coverage must waive employee coverage.

However, if your spouse or registered same-sex domestic partner works full-time for an employer and receives cash or credits (1) in place of medical coverage, or (2) in exchange for a medical coverage with a deductible of \$750 or greater, then he/she is not considered to be an eligible dependent under the Plan.

Same-sex domestic partner registration criteria:

- a) Engaged in a committed relationship and intend to remain together indefinitely;
- b) Are the same-sex and for this reason are unable to marry each other under Minnesota law;
- c) Are at least 18 years of age and have the capacity to enter into a contract;
- d) Are jointly responsible to each other for the necessities of life; and
- e) Are not related by blood closer than permitted under Minnesota marriage laws.

Contact Employee Benefits at 612-624-9090 or 1-800-756-2363 (press 2) for the forms to register your same-sex domestic partner.

5. Taxability of Coverage for Your Registered Same-sex Domestic Partner and the Child/Children of Registered Same-Sex Domestic Partner

Under IRS rules, the value of the medical and dental coverage provided by the University to your registered same-sex domestic partner and the child/children of your registered same-sex domestic partner is generally considered taxable income to you as the employee. The only exception to the taxability of these benefits is if your registered same-sex domestic partner and his or her children meet the following IRS definition of a dependent.

A registered same-sex domestic partner and his/her children can meet the definition of a dependent for the purposes of family coverage if the following conditions are met:

- a) They lived with you for the entire year as a member of your household,
- b) They were U.S. citizens or resident aliens of the U.S. or residents of Canada or Mexico for part of the calendar year in which your tax year began,

- c) They did not file a joint tax return,
- d) You provided over half of their support for the calendar year, and
- e) They are not a dependent child for tax purposes of any other individual.

If your registered same-sex domestic partner and children meet all of the above requirements, you will need to complete a *Certification of Dependent Status* form. Information and the form can be found on the Web site at <http://www1.umn.edu/ohr/benefits/domesticpartner/index.html> or by contacting Employee Benefits.

6. Definition of Full-Time Student for Tax Favored Status Determination

- a) Children ages 19 through 24 are eligible for UPlan medical and/or dental coverage regardless of whether the child is a full-time student. However, being a full-time student is one way that an individual qualifies for tax favored treatment under the Plan. The following definition of a student for the Plan is recorded in IRS Publication 501 and is as follows:

“A full-time student is a student who is enrolled for the number of hours or courses the school considers to be full-time attendance.

To qualify as a student, your child must be, during some part of each of any 5 calendar months of the year:

1. A full-time student at a school that has a regular teaching staff, course of study, and a regularly enrolled student body at the school, or
2. A student taking a full-time, on-farm training course given by a school described in (1) or by a state, county, or local agency.

The 5 calendar months do not have to be consecutive.

A school can be a high school, college, university, or technical, trade, or mechanical school. However, an on-the-job training course, correspondence school, or school offering courses only through the internet does not count as a school. Students who work on “co-op” jobs in private industry while part of a high school’s regular course of classroom and practical training are considered full-time students.”

- b) If a child in the 19 through 24 year age bracket no longer retains full-time student status, he/she may still qualify for tax favored treatment under the plan if he/she is more than 50% dependent on the employee for support. If the child does not meet either of the criteria for tax favored coverage shown in the chart above, the child will still be eligible for the Plan, but coverage will not be on a tax favored basis.

7. Coverage of Disabled Children of Any Age

- a) Your dependent child of any age is eligible for coverage and tax favored status if he/she is incapable of self-sustaining employment by reason of mental retardation, mental illness, mental disorder, or physical disability, and is chiefly dependent upon you for his/ her support and maintenance (meaning you provide for more than one-half of the child’s support).
- b) A dependent child must be certified by the Plan Administrator to be disabled prior to age 25, based on proof that the child meets the above requirements.

- i) If for any reason, you drop coverage for a disabled dependent prior to age 25, then wish to cover the child again, coverage must be added prior to the child turning age 25, and his/her disabled status recertified by the Plan Administrator.
 - ii) Once your disabled child has reached age 25, the child must be continuously covered under the Plan in order to maintain eligibility.
- c) A disabled dependent child who is 25 years of age or older and unmarried at the time of your initial eligibility for coverage in the Plan, may be enrolled for coverage if:
- i) You (the employee) enroll for coverage during your initial eligibility period, and;
 - ii) The Plan Administrator certifies that the dependent meets the above requirements. Proof of disability status must be provided within 31 days of your initial date of eligibility and enrollment in the Plan. The disabled dependent shall be eligible for coverage as long as he/she continues to be disabled and dependent, unless coverage otherwise terminates under the Plan.

A dependent child who is considered to be disabled by the Plan Administrator will be eligible for tax favored coverage under the Plan, regardless of age. The disabled child of a registered same-sex domestic partner will not be eligible for tax favored coverage.

8. Children Covered by Child Support Order

Children of the employee who are required to be covered by reason of a Qualified Medical Child Support Order are eligible, as required by federal and state law to assure that children who do not live with both of their biological parents have adequate medical coverage. This provision does not apply to children of the spouse/registered same-sex domestic partner who are not also children of the employee.

9. Not Eligible

For purposes of coverage under the Plan, your parents, grandparents, in-laws, brothers, sisters, cousins and other extended family members, non-registered same-sex domestic partners and their children, and unmarried opposite-sex domestic partners and common-law spouses are not eligible dependents.

10. Family Status Changes

To make changes in your medical, dental, optional life coverage, or flexible spending accounts after you are first eligible or outside of the annual open enrollment period, you must have a change in family status. The coverage change must be consistent with the family status change. A request for change in your coverage due to a family status change must be made within 30 days of the date of change. Failure to apply for a change in coverage within 30 days of the family status change means that you will not be able to make a change until the next available open enrollment period.

Family status changes include:

- Change in legal marital status, including marriage, divorce, legal separation, or annulment.
- Registration of your same-sex domestic partnership or termination of same-sex domestic partnership.
- Death of your spouse/registered same-sex domestic partner or last eligible dependent child.

- Birth or adoption of your first eligible dependent child.
- Change in last dependent child's eligibility because of age or student status.
- Commencement or termination of employment for you, spouse/registered same-sex domestic partner, or dependent.
- Changes in your or your spouse/registered same-sex domestic partner's employment status from part-time to full-time or from full-time to part-time.
- Change in the place of residence or worksite for you, spouse/registered same-sex domestic partner, or dependent to a location outside of the current plan's service area and the current plan is not available.

Call Employee Benefits if you have more specific questions about changes in your coverage.

Effective Dates of Coverage

1. The initial effective date of coverage is the first day of the month following the first day employment, reemployment, or reinstatement. You must be actively at work on the initial effective date of coverage, or coverage will be delayed until the first day of the payroll period following the date the employee returns to active payroll status. However, if you are not actively at work on the initial effective date of coverage due to your health status, medical condition, or disability, or that of your dependent, as such terms are defined in Section 9802(a) of the Internal Revenue Code and related regulations, coverage shall not be delayed.
2. If you and your dependents apply for coverage during an open enrollment period, coverage will become effective on January 1 of the following year.
3. A newborn child's coverage takes effect from the moment of birth.
4. Adopted children are covered from the date of placement for the purposes of adoption.
5. Handicapped dependents are covered from your effective date of coverage.
6. For the purposes of this entire section, a dependent's coverage may not take effect prior to an employee's coverage.

Open Enrollment

The Open Enrollment under this Contract shall be held annually.

Termination of Coverage

Your coverage and that of your eligible dependents ceases on the earliest of the following dates:

- a) See Below* for your date of termination if (1) you cease to be eligible; (2) your dependent is no longer eligible as a dependent under the Program.

* Active Employees and dependent(s)	End of pay period
Retirees and dependent(s)	Last day of the month
COBRA and dependent(s)	Last day of the month
Participants on Disability Status and dependent(s)	Last day of the month
Dependent Child	Last day of the month in which child is no longer eligible

- b) On the date the Program is terminated.
- c) On the date the Group terminates the Program by failure to pay the required Group Subscriber payments, except as a result of inadvertent error.

For extended eligibility, see Continuation of Coverage.

The Group or Plan Sponsor reserves the right to terminate the Plan, in whole or in part, at any time (subject to applicable collective bargaining agreements). Termination of the Plan will result in loss of benefits for all covered persons. If the Plan is terminated, the rights of the Plan Participants are limited to covered expenses incurred before termination.

Continuation of Coverage (COBRA)

COBRA Notice

This notice contains important information concerning your right to COBRA continuation coverage – a temporary extension of benefit coverage under the UPlan that can become available to you and other eligible members of your family in the event you later lose group coverage through the plan. The right to COBRA continuation was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Under the University of Minnesota UPlan, COBRA coverage applies to medical and dental benefits and the flexible spending account. Minnesota state law continuation applies to life insurance benefits.

Note: This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

This notice provides a summary of your COBRA continuation rights. For more information about your rights and obligations under the UPlan and under federal law, you should review the Eligibility section.

Continuation of Coverage

COBRA continuation coverage is a continuation of UPlan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the UPlan because of a qualifying event. Depending on the type of qualifying event, employees, spouses and dependent children may be qualified beneficiaries. Under COBRA, registered same-sex domestic partners are not considered qualified beneficiaries, however, the University will provide continuation benefits to registered same-sex domestic partners on the same terms and conditions as if they were qualified beneficiaries under COBRA. The term qualified beneficiary when used in the University’s COBRA continuation materials will therefore be deemed to apply to registered same-sex domestic partners. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage.

1. If you are an employee, you will become a qualified beneficiary if you will lose coverage under the UPlan due to one of the following qualifying events:
 - a) your hours of employment are reduced below a 50 to 74 percent time appointment; or
 - b) your employment is terminated for any reason other than gross misconduct

2. If you are the spouse/same-sex domestic partner of an employee, you will become a qualified beneficiary if you will lose your coverage under the UPlan because any of the following qualifying events:
 - a) employee dies;
 - b) employee's hours of employment are reduced;
 - c) employee's employment ends for any reason other than his or her gross misconduct;
 - d) employee retires at age 65 or over and enrolls in Medicare (Part A, Part B); or
 - e) employee divorces or legally separates, or terminates same-sex domestic partnership.
3. Your dependent children will become qualified beneficiaries if they will lose coverage under the UPlan because of any of the following qualifying events:
 - a) employee dies;
 - b) employee's hours of employment are reduced;
 - c) employee's employment ends for any reason other than his or her gross misconduct;
 - d) employee retires at age 65 or over and enrolls in Medicare (Part A, Part B); or
 - e) dependent child is no longer eligible for coverage because he or she has reached age 25 or has otherwise lost eligibility for the program; or
 - f) employee is divorced or legally separated, or same-sex domestic partnership is terminated.

The UPlan will offer COBRA continuation coverage to qualified beneficiaries only after Employee Benefits has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, death of the employee, or retirement of an employee age 65 or over and enrollment of same employee in Medicare (Part A, Part B, or both); the employer (department, college, or area) must notify Employee Benefits of the qualifying event within 30 days of any of these events. Your coverage will terminate at the end of the month in which a qualifying event has occurred unless you elect COBRA continuation coverage. You have 60 days from the date of loss of coverage to elect COBRA continuation coverage.

Note: For other qualifying events – divorce or legal separation, termination of a same-sex domestic partnership, or a dependent child losing eligibility for coverage – you must notify Employee Benefits within 30 days after the qualifying event occurs. You must either send a letter of notification to: Employee Benefits, 100 Donhowe Building, 319 15th Avenue SE, Minneapolis, MN 55455; or call the Employee Benefits Service Center at **612-624-9090 or 1-800-756-2363, and press option 2**. Employee Benefits will send you the appropriate form to complete. This form must then be completed and sent to Employee Benefits at the address above, and postmarked within the 30-day time limitation. Your coverage will terminate at the end of the month in which the qualifying event occurs unless you elect COBRA continuation coverage. You have 60 days from the date of loss of coverage to elect COBRA continuation coverage.

Once Employee Benefits notifies the UPlan COBRA Administrator that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA, coverage will begin on the date the UPlan coverage would otherwise have been lost.

Qualifying Events Determine Length of Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee the COBRA continuation coverage period continues until coverage would have terminated had this event not occurred.

When the qualifying event is a dependent child losing eligibility, divorce or legal separation, or termination of same-sex domestic partnership, the COBRA continuation coverage period is 36 months. When the qualifying event is the end of employment or a reduction in the employee's hours of employment, COBRA continuation coverage is available for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

1. Disability extension of the 18-month period of continuation coverage

If you or anyone in your family who is currently covered under the UPlan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months.

You must make sure that Employee Benefits is notified of the Social Security Administration's (SSA) determination within 60 days of the latest of:

- 1) the date of the SSA determination,
- 2) the date of the qualifying event,
- 3) the date of the loss of coverage, or
- 4) the date you are informed of your obligation and the procedure to provide this information,

and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the UPlan COBRA Administrator. If you fail to notify Employee Benefits in writing and postmarked within the time limit, you will lose your right to extend coverage due to disability. Under this provision, you must also notify Employee Benefits within 30 days if the SSA determination is revoked.

2. Second qualifying event extension of the 18-month period of continuation coverage

If another qualifying event occurs during COBRA continuation coverage, your spouse/same-sex domestic partner and dependent children in your family may be eligible for additional months of COBRA continuation coverage, up to a maximum of 36 months. The second qualifying event must be one that would have caused a loss of coverage if your spouse/same-sex domestic partner and dependent children in your family were not currently receiving COBRA continuation coverage. This extension is available to the spouse/same-sex domestic partner and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), is divorced or legally separated, or has a termination of same-sex domestic partnership. The extension is also available to a dependent child who is no longer eligible under the UPlan as a dependent child. In all of these cases, you must make sure that Employee Benefits is notified in writing within 60 days of the second qualifying event. This notice must be sent to the UPlan COBRA Administrator. If you fail to notify Employee Benefits in writing and postmarked within the time limit, you will lose your right to extend coverage.

End of COBRA Continuation Coverage

Your COBRA continuation coverage may be terminated prior to the end of the continuation period for any of the following reasons:

1. University of Minnesota no longer provides group insurance to any of its employees.
2. The premium for your continuation coverage is not paid in a timely fashion.

Note: You will have 45 days from the date you elect COBRA continuation coverage in which to make your first premium payment to the UPlan COBRA Administrator. After the first payment, there is a 30-day grace period for all future payments. For example: All regular COBRA continuation payments are due on the first day of the month. If your payment is due on January 1, your payment must be postmarked within 30 days or January 30. Payments made after the 30-day grace period will be returned to you and all coverage will be cancelled as of the end of the month in which the last regular payment was made.

3. After making your COBRA election, you become covered under another group plan that does not include a pre-existing condition clause that applies to you or eligible dependents.
4. After making your COBRA election, you or your dependents become covered under Medicare (Part A, Part B, or both).
5. A final determination has been made by the Social Security Administration that you are no longer disabled. Termination of coverage is effective in the month that begins more than 30 days after the final determination.

Keep Your Plan Informed of Address Changes

In order to protect the rights of you and your family, you should keep Employee Benefits informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices sent by you to Employee Benefits or to the UPlan COBRA Administrator. Employee Benefits can be contacted at the Employee Benefits Service Center information listed below.

Questions About Billing

The UPlan COBRA Administrator is responsible for administering COBRA continuation coverage. If you have any questions about your billing, you may contact the appropriate UPlan COBRA Administrator directly.

1. UPlan COBRA Administrator — Medical, Dental and Life Insurance:

For billing questions about medical or dental benefits or life insurance coverages, the UPlan COBRA Administrator is:

Eide-Bailly Employee Benefits
5601 Greenvally Drive, Suite 710
Bloomington, MN 55437
Phone: 952-944-6633
Toll Free: 1-800-300-16722.

2. UPlan COBRA Administrator — Flexible Spending Account:

For billing questions about the flexible spending account, contact:

Employee Benefits Service Center
612-624-9090 or 1-800-756-2363, and press option 3

Questions About Coverage

If you have questions about your COBRA coverage, you should contact Employee Benefits Service Center at 612-624-9090 or 1-800-756-2363, and press option 2, 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 the Regional and District EBSA Offices are available through the EBSA Web site at www.dol.gov/ebsa.

PLAN PAYMENTS

Covered Fees

Under this Program you must see a Delta Dental PPO dentist in order to receive benefits.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN THE DELTA DENTAL PPO NETWORK PRIOR TO RECEIVING DENTAL CARE.

Claim Payments

PAYMENTS ARE MADE BY THE PLAN ONLY WHEN THE COVERED DENTAL PROCEDURES HAVE BEEN COMPLETED. THE PLAN MAY REQUIRE ADDITIONAL INFORMATION FROM YOU OR YOUR PROVIDER BEFORE A CLAIM CAN BE CONSIDERED COMPLETE AND READY FOR PROCESSING. IN ORDER TO PROPERLY PROCESS A CLAIM, THE PLAN MAY BE REQUIRED TO ADD AN ADMINISTRATIVE POLICY LINE TO THE CLAIM. DUPLICATE CLAIMS PREVIOUSLY PROCESSED WILL BE DENIED.

ANY BENEFITS PAYABLE UNDER THIS PLAN ARE NOT ASSIGNABLE BY ANY COVERED PERSON OR ANY ELIGIBLE DEPENDENT OF ANY COVERED PERSON.

Delta Dental PPO Dentists:

Claim payments are based on the Plan's Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental PPO dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental PPO dentists is the lesser of: (1) The fee pre-filed by the dentist with their Delta Dental organization; (2) The Delta Dental PPO Maximum Amount Payable as determined by Delta Dental; (3) The fee charged or accepted as payment in full by the Delta Dental PPO dentist regardless of the amount charged. All Plan Payment Obligations are determined prior to the calculation of any patient co-payments and deductibles as provided under the patient's Delta Dental program.

THE COVERED PERSON IS RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY A DENTIST NOT IN THE DELTA DENTAL PPO NETWORK.

Coordination of Benefits (COB)

This section applies when you have dental care coverage under more than one plan, as defined below. If this section applies, you should look at B. Order of Benefits Rules to determine which plan determines benefits first. Your benefits under this Plan are not reduced if the Order of Benefits Rules requires this Plan to pay first. Your benefits under this Plan may be reduced if another plan pays first.

A. Definitions

These definitions apply only to this section.

1. "Plan" is any of the following that provides benefits or services for, or because of, dental care or treatment:

- a) Group insurance or group-type coverage, whether insured or uninsured; this includes prepayment, group practice, individual practice coverage, and group coverage other than school accident-type coverage.
 - b) Coverage under a government plan or one required or provided by law.
2. "This Plan" means the part of the Plan that provides dental care benefits.
3. "Primary plan/secondary plan" is determined by the Order of Benefits Rules. When this Plan is a primary plan, its benefits are determined before any other plan and without considering the other plan's benefits. When this Plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When you are covered under more than two plans, this Plan may be a primary plan to some plans and may be a secondary plan to other plans.
4. "Allowable expense" means the necessary, reasonable, and customary items of expense for dental care, covered at least in part by one or more plans covering the person making the claim. "Allowable expense" does not include an item or expense that exceeds benefits that are limited by statute or this Plan.

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

5. "Claim determination period" means a Plan Year. However, it does not include any part of a year the person is not covered under this Plan, or any part of a year before the date this section takes effect.

B. Order of Benefits Rules

1. **General.** When a claim is filed under this Plan and another plan, this Plan is a secondary plan and determines benefits after the other plan, unless:
- a) the other plan has rules coordinating its benefits with this Plan's benefits; and
 - b) the other plan's rules and this Plan's rules require this Plan to be primary.
2. **Rules.** This Plan determines benefits using the first of the following rules that applies:
- a) **Subscriber.** The plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) determines its benefits before the plan that covers the person as a dependent.
 - b) **Dependent child of parents not separated or divorced.** When this Plan and another plan cover the same child as a dependent of different persons, called "parents":
 - i) the plan that covers the parent whose birthday falls earlier in the year determines benefits before the plan that covers the parent whose birthday falls later in the year; but
 - ii) if both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time.

However, if the other plan does not have this rule for children of married parents/registered same-sex domestic partners, and instead has a rule based on the gender of the parent, and, if as a result the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.

- c) **Dependent child of parents divorced or separated.** If two or more plans cover a dependent child of divorced or separated parents, the plan determines benefits in this order:
 - i) first, the plan of the parent with custody of the child;
 - ii) then, the plan that covers the spouse/same-sex domestic partner of the parent with custody of the child;
 - iii) finally, the plan that covers the parent not having custody of the child.

However, if the court decree requires one of the parents to be responsible for the dental care expenses of the child, and the plan that covers that parent has actual knowledge of that requirement, that plan determines benefits first. This does not apply to any claim determination period or plan year during which any benefits are actually paid or provided before the plan has that actual knowledge.

- d) **Active/inactive employee.** The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) determines benefits before a plan that covers that person as a laid off or retired employee (or as that employee's dependent). This rule will not apply unless the other plan has the same rule.
- e) **Longer/shorter length of coverage.** If none of the above rules determines the order of benefits, the plan that has covered an employee, member, or subscriber longer determines benefits before the plan that has covered that person for the shorter time.

C. Effect on Benefits of This Plan

1. When Order of Benefits Rules requires this Plan to be a secondary plan, this part applies. Benefits of this Plan may be reduced.
2. Reduction in this Plan's benefits takes place when the sum of a) and b) below exceeds those allowable expenses in a claim determination period. In that case, the benefits of the dental portion of this Plan are reduced so that benefits payable under all plans do not exceed allowable expenses. When benefits of this plan are reduced, each benefit is reduced in proportion and charged against any applicable benefit limit of this Plan.
 - a) the benefits payable for allowable expenses under this Plan, without applying coordination of benefits, and
 - b) the benefits payable for allowable expenses under the other plans, without applying coordination of benefits or a similar provision, whether or not claim is made.

D. Right to Receive and Release Needed Information

Certain facts are needed to apply these Coordination of Benefits rules. The Claims Administrator has the right to decide which facts are needed. The Claims Administrator may get needed facts from, or give them to, any other organization or person. The Claims Administrator does not need to tell, or get the consent of, any person to do this unless applicable federal or state law prevents disclosures of information without the consent of the patient or patient's representative. Each person claiming benefits under this plan must provide any facts needed to pay the claim.

E. Facility of Payment

A payment made under another plan may include an amount that should have been paid under this Plan. If this happens, the Claims Administrator may pay that amount to the organization that made that payment. That amount will then be considered a benefit paid under this Plan. The Claims Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

F. Right of Recovery

If the Claims Administrator pays more than it should have paid under these Coordination of Benefits rules, it may recover the excess from any of the following:

1. The persons it paid or for whom it has paid
2. Insurance companies
3. Other organizations

The amount paid includes the reasonable cash value of any benefits provided in the form of services.

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. However, this 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 the address shown on the Explanation of Benefits.

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.

Claim or Administrative Appeals to University of Minnesota Employee Benefits Department

If your claim for benefits under the plan is wholly or partially denied by the Claims Administrator, you may request a review of your claim by the University of Minnesota's Employee Benefits Review Committee. Your request must be in writing and received by Employee Benefits, University of Minnesota, 100 Donhowe Building, 319 15th Avenue SE, Minneapolis, MN, 55455-0103, within 60 days of the denial of your appeal by the Claims Administrator. A written decision will be mailed to you by Employee Benefits within 30 days of the receipt of your request for review by the Employee Benefits Review Committee.

Within 60 days of receiving notice of a claim denial from the Employee Benefits Review Committee, you may submit a final, written appeal to the Employee Benefits Director. Your appeal should be submitted to Employee Benefits, University of Minnesota, 100 Donhowe Building, 319 15th Avenue SE, Minneapolis, MN 55455-0103. The Employee Benefits Director will render a final written decision regarding your appeal within 45 days of your written request.

If you are disputing a determination concerning an eligibility, enrollment or other administrative issue, you may contact the University's Benefits Service Center directly, by telephone (612-624-9090 or 800-756-2363), fax (612-626-0808), or by mail to Employee Benefits Service Center within 90 days of the date that the eligibility, enrollment, or other administrative issue first became apparent.

GENERAL INFORMATION

Health Plan Issuer Involvement

The benefits under the Plan are not guaranteed by Delta under the Contract. As Claims Administrator, Delta pays or denies claims on behalf of the Plan and reviews requests for review of claims as described in the Claim and Appeals Procedures section.

Privacy Notice

Delta Dental of Minnesota will not disclose non-public personal financial or health information concerning persons covered under our dental benefit plans to non-affiliated third parties except as permitted by law or required to adjudicate claims submitted for dental services provided to persons covered under our dental benefit plans.

Cancellation and Renewal

The Program may be canceled by the Plan only on an anniversary date of the Group Dental Plan Contract, or at any time the Group fails to make the required payments or meet the terms of the Contract.

Upon cancellation of the Program, Covered Persons of the Group have no right to continue coverage under the Program or convert to an individual dental coverage contract.

DELTA DENTAL OF MINNESOTA

FOR CLAIMS AND ELIGIBILITY

P.O. Box 330
Minneapolis, Minnesota 55440-0330
(651) 406-5916 or (800) 553-9536

FOR APPEALS

P.O. Box 551
Minneapolis, Minnesota 55440-0551

CORPORATE LOCATION

3560 Delta Dental Drive
Eagan, Minnesota 55122-3166
(651) 406-5900 or (800) 328-1188
www.deltadentalmn.org

CORPORATE MAILING ADDRESS

P.O. Box 9304
Minneapolis, Minnesota 55440-9304
(651) 406-5900 or (800) 328-1188



P.O. Box 330
Minneapolis, Minnesota 55440-0330