Group Dental Summary Plan Description

For Associates of:
Blue Cross and Blue Shield of Minnesota

2024 Enhanced Dental Plan
Group Dental Plan

PLEASE READ YOUR BOOKLET CAREFULLY

Language Access Services

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

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

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

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

နမ့်ကတိၤကသိကျိာ်ဒီး, တ၀်ကဟ့ဉ်နၤကျိာ်တ၀်မၤစ၊ၤကလိတဖဉ်နှဉ်လိၤ. ကိး 1-866-251-6744 လ၊ TTY အဂိ်၊, ကိး 711 တက့၀်.

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

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

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

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

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

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

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

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

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

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

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

Notice of Nondiscrimination Practices

Effective July 18, 2016

The claims administrator complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

The claims administrator provides resources to access information in alternative formats and languages:

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

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

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

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

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

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

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

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

Questions?

Contact Us

Our customer service staff is available to answer your questions.

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

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

Hours are subject to change without prior notice.

Customer Service Telephone Number	For claims and benefit inquiries call 1-888-589-2447. For all other inquires, such as member ID cards, please call 1-866-873-5943.
Interpreter Services	See "Language Access Services."
Website	bluecrossmn.com/associate
Mailing Address	Claims review requests and inquiries may be mailed to the address below: Dental Claims Administration P.O. Box 69449 Harrisburg, PA 17106-9449

IMPORTANT! The claims administrator issues each member an identification (ID) card. If any of the information on your member ID card is not correct, please contact the claims administrator immediately. When receiving care, present your member ID card to the dental care provider who is rendering the services.

A copy of the claims administrator’s privacy procedures is available on the claims administrator’s website or by calling 1-800-382-2000.

Table of Contents

Welcome

This Summary Plan Description (or SPD), also referred to as a benefit booklet, provides you with the information you need to understand your plan. You are encouraged to take the time to review this entire SPD so you understand how your plan works.

This SPD replaces all other certificates/benefit booklets you have received from the plan administrator before the effective date. For purposes of this SPD, "you" or "your" refers to the associate named on the identification (ID) card and other covered dependents. Associate is the person for whom the employer has provided coverage as a result of an employment relationship. Dependent is a covered dependent of the associate.

The plan administrator has contracted with the claims administrator to provide coverage for its associates and their dependents.

Certain terms used in this SPD have specific meanings, as explained in "Terms You Should Know."

This SPD explains the plan, eligibility, notification procedures, covered services, and expenses that are not covered. It is important that you read this entire SPD carefully. If you have questions about your coverage, please contact customer service at the telephone number listed on the back of your member ID card or log onto your claims administrator’s member website at bluecrossmn.com/associate.

This plan, financed and administered by Blue Cross and Blue Shield of Minnesota, is a self-insured plan. Blue Cross and Blue Shield of Minnesota (Blue Cross) is also the claims administrator and provides administrative services. Coverage is subject to all terms and conditions of this benefit booklet, including medical necessity and appropriateness.

Your Benefits

This benefit booklet provides coverage of benefits for a pre-determined schedule of dental services. It does not pay benefits for any other type of expense. Please be certain to check the “Schedule of Benefits” section below to identify specifically covered benefits. All services must be medically necessary and appropriate to be covered.

Please also review the limitations section of the “Schedule of Benefits” and "Services that are not Covered" sections to determine services that are not covered. Some services and supplies are not covered, even if a provider considers them to be medically necessary and appropriate.

The "Terms You Should Know" section defines terms used in this benefit booklet. If you have questions, contact customer service using the telephone number listed on the back of your member ID card.

Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services you receive during your covered calendar year will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether you have satisfied your deductible.

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

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

All coverage of benefits for dependents and all references to dependents in this benefit booklet are inapplicable for associate-only coverage.

Your plan’s benefit period is based on a calendar year. The calendar year is January 1 to December 31.

During this time, charges for covered services must be incurred in order to be eligible for payment by the claims administrator. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

Pre-Determination

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

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

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

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

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

Schedule of Benefits

Networks

Networks	
Your online provider directory lists in-network providers in our service area and may change from time to time, including as providers or the claims administrator initiate or terminate network contracts. Prior to receiving services, it is recommended that you verify your provider's network status with the claims administrator, including whether the provider is in-network for your particular plan. Not every provider is in-network for every plan. To find an in-network provider, visit bluecrossmn.com/associate (or contact customer service at the telephone number listed on the back of your member ID card.)	
In-network Providers	Advantage Plus AXS
Out-of-Network Providers	Eligible providers other than Advantage Plus AXS network providers

Deductibles and Maximums

Deductibles	**Participating Provider** (In-Network) You Pay	**Nonparticipating Provider** (Out-of-Network) You Pay
Calendar Year Deductible	$25 per member $75 per family Waived for Class I services and waived for orthodontics	$50 per member $150 per family Waived for Class I services and waived for orthodontics

Annual Maximums	**Applies to the combination of services received from Participating Provider (in-network) and Nonparticipating Provider (out-of-network)**
Calendar Year Benefit Plan Maximums	The plan will pay up to $3.000 per member for in-network The plan will pay up to $1,000 per member for out-of-network **not to exceed $1,000 combined for in-and out-of-network per member**

Lifetime Maximums	**Applies to the combination of services received from Participating Provider (in-network) and Nonparticipating Provider (out-of-network)** The Plan Pays Up to
Orthodontic Lifetime Maximum – Orthodontic services only (separate from other services)	$2,000 per member

Preventive Incentive: Benefits for the following services shown as covered on the "Schedule of Benefits" will not be counted toward accumulation of the calendar year maximum indicated:	
• Exams • All X-Rays • Cleanings (routine prophylaxis) • Fluoride Treatments	• Sealants • Palliative Treatment (Emergency) • Space Maintainers

Class I – Diagnostic/Preventive Services and Limitations

Benefit Category (and Limitations)	Participating Provider (In-Network) The Plan Pays	Nonparticipating Provider (Out-of-Network) The Plan Pays
Exams (Oral Evaluations)		
• Comprehensive (2 examinations per calendar year combined with Periodic)	100%	80%
• Periodic (2 examinations per calendar year combined with Comprehensive)	100%	80%
• Limited, Problem Focused (2 examinations per calendar year)	100%	80%
• Detailed, Problem Focused (2 examinations per calendar year)	100%	80%
Cleanings (Prophylaxis) (2 per calendar year. 1 additional for members under the care of a medical professional during pregnancy)	100%	80%
Fluoride Treatments (Topical application - 1 per calendar year for dependent children only under the age of 14)	100%	80%
X-Rays		
• Full Mouth X-Rays (1 every 5 calendar years age 5 and older)	100%	80%
• Bitewing X-Rays (1 set per 12 months under age 19 and 1 set per 18 months age 19 and older)	100%	80%
• All other X-Rays ▪ Occlusal – 2 per 12 months under age 8 ▪ Periapical – 4 per 12 months	100%	80%
Sealants (1 per tooth per 3 calendar years for dependent children only under the age of 16 on the primary and permanent first and second molars)	100%	80%
Palliative Treatment (Emergency) (2 per 12 months in combination with pulpal debridement)	100%	80%
Space Maintainers (1 per 5 year period for dependent children only under the age of 14 only eligible on primary molars and permanent first molars)	100%	80%

Class II – Basic Services and Limitations

Benefit Category (and Limitations)	Participating Provider (In-Network) The Plan Pays	Nonparticipating Provider (Out-of-Network) The Plan Pays
Basic Restorative		
• Amalgams (silver fillings)	80%	60%
• Anterior resins (white fillings)	80%	60%
• Posterior resins	80%	60%
Repairs		
• Denture repairs	80%	60%
• Fixed denture repairs	80%	60%
• Crown repairs (not within 5 calendar years of insertion)	80%	60%
• Recementation (1 per 3 calendar years)	80%	60%
Buildups, Post and Cores		
• Buildups, Post and Cores (not within 5 calendar years of previous placement of any of the procedures in this category)	80%	60%
• Prefabricated stainless steel crowns (1 per tooth per lifetime for dependent children only under the age of 14)	80%	60%
Denture Adjustments		
• Denture relining and rebasing	80%	60%
• Other denture adjustments	80%	60%
• Adjustment of prosthetic services – not within 6 months of insertion; 2 per 24 months thereafter		
Simple Extractions	80%	60%
Complex Oral Surgery	80%	60%
Anesthesia (a total of 60 minutes per session)		
• General Anesthesia	80%	60%
• IV sedation	80%	60%
• Nitrous Oxide (for dependent children only under the age of 13)	80%	60%

Benefit Category (and Limitations)	Participating Provider (In-Network) The Plan Pays	Nonparticipating Provider (Out-of-Network) The Plan Pays
Surgical Periodontal Treatment (1 per 36 months per area of the mouth) Guided tissue regeneration 1 per tooth per lifetime	80%	60%
Non-Surgical Periodontics		
• Periodontal maintenance following active periodontal therapy (2 per calendar year in addition to routine cleaning)	80%	60%
• Full mouth debridement (1 per lifetime)	80%	60%
• Scaling and root planing (1 per 24 months per area of the mouth)	80%	60%
Endodontics		
• Pulpal therapy (1 per primary tooth per lifetime only when there is not permanent tooth to replace it)	80%	60%
• Root canal treatment (1 per tooth per lifetime)	80%	60%
• Root canal retreatment (1 per tooth per lifetime)	80%	60%

Class II – Basic Services Additional Limitations

Benefit Category	Limitations
Basic Restorative	• Restorative services (e.g. fillings) covered only when existing basic restorations are not, and cannot be made, serviceable: ▪ Not within 24 months of previous placement of any basic restoration
Repairs	▪ Recementation during the first 12 months following insertion of any preventive, restorative or prosthodontic service by the same dental provider is included in the preventive, restorative or prosthodontic service benefit
Buildups, Posts and Cores	• Restorative services only when existing buildups, posts and cores are not, and cannot be made, serviceable
Denture Adjustments	• Denture relining, rebasing or adjustments are considered part of the denture charges if provided within 6 months of the insertion by the same dental provider. Subsequent denture relining or rebasing limited to 3 calendar years thereafter

Class III – Major Services and Limitations

Benefit Category (and Limitations)	**Participating Provider** (In-Network) The Plan Pays	**Nonparticipating Provider** (Out-of-Network) The Plan Pays
Inlays, Onlays, Crowns (Not within 5 calendar years of previous placement of any of the procedures in this category age 14 years and older only)	60%	50%
Prosthetics (Dentures) (limited to age 17 and older only) (Bridges are limited to age 14 and older only) (Dentures are limited to age 17 and older only)		
• Removable dentures	60%	50%
• Fixed partial dentures	60%	50%
Temporomandibular Disorder/ Reconstructive Surgery	60%	50%
Orthodontics (limited to members under age 19)	50%	50%
Implant Placement • Endosteal • Eposteal • Transosteal • Mini	60%	50%
Implant Surgical Services • Second stage implant surgery • Implant removal • Debridement of preiimplant defects • Debridement and osseous contouring of preiimplant defect • Bone graft at time of implant placement	60%	50%
Implant Supporting Structures • Connecting bar • Prefabricated abutment • Custom fabricated abutment	60%	50%
Implant/Abutment Supported Prosthetics • Removable dentures • Fixed dentures (hybrid prosthesis) • Single crown • Fixed partial dentures	60%	50%

Benefit Category (and Limitations)	Participating Provider (In-Network) The Plan Pays	Nonparticipating Provider (Out-of-Network) The Plan Pays
Other Implant Related Procedures • Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla • Sinus augmentation, lateral open approach • Sinus augmentation, vertical approach • Bone replacement graft for ridge preservation • Cone beam diagnostic imaging	60%	50%

Class III – Major Services Additional Limitations

Benefit Category	Limitations
Prosthetics (Dentures)	Restorative services only when they are not, and cannot be made, serviceable: • Replacement of natural tooth/teeth in an arch - not within 5 calendar years of a fixed partial denture, full denture or partial removable denture.
Reconstructive Surgery	• Congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment) only when related to services that are scheduled or initiated prior to the member turning age 19. • Dental reconstructive surgical services when such dental service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent under age 19 because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician.
Orthodontics	• Payment for orthodontic services, if covered, shall cease at the end of the month after termination by the claims administrator
Implantology Services	• All implantology services are limited to members age 18 and older • All implantology services (not inclusive of prosthetics) are limited to one (1) per tooth per lifetime • Replacement of implant prosthetics are limited to 1 per 5 calendar years • Mini implants limited to one (1) per tooth per lifetime and a maximum of four (4) per arch per lifetime, in support of a complete removable denture • Cone beam diagnostic imaging limited to one (1) digital image per lifetime

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

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

Services that are not Covered

No benefits will be provided for services, supplies, or charges detailed under "Schedule of Exclusions" unless defined within the "Schedule of Benefits" section of the benefit booklet. No benefits will be provided for services, supplies or charges that exceed the Limitations described in the “Schedule of Benefits” section.

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

Even though your provider may recommend or provide written authorization for a referral for certain services, the dental care provider may be a nonparticipating provider or the recommended services may be excluded or limited. When these services are referred or recommended, a written authorization from your provider does not override any provisions in the "Schedule of Benefits" or the "Schedule of Exclusions."

No payment of benefits will be allowed under this plan including payments for services you have already received prior to the effective date of this coverage or after coverage ends.

Schedule of Exclusions

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

If a fee or expense charged by a nonparticipating provider for a covered service or supply exceeds the maximum allowable charge or the usual, customary and reasonable allowance (as applicable), the plan will not pay for the excess amount.

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

The following services, supplies or charges are excluded:

Services and Procedures

1. Those specifically listed on the "Schedule of Benefits" as "Not Covered" or that exceed a limitation as described in the “Schedule of Benefits”.
2. For plaque control programs, tobacco counseling, oral hygiene, and dietary instructions.
3. Preventive restorations.
4. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the "Schedule of Benefits."
5. Services and/or appliances that alter the vertical dimension to restore tooth structure lost from attrition, erosion or abrasion, appliances, or any other method. For example (but not limited to):
    a. Full-mouth rehabilitation
    b. Splinting
    c. Fillings
6. Periodontal splinting of teeth by any method.
7. Replacement or repair of lost, stolen, or damaged prosthetic or orthodontic appliances.

8. Orthodontic services, supplies, and appliances are not covered unless otherwise noted.
9. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the "Schedule of Benefits," if applicable.
10. Implantology services are excluded if such services replace one (1) or more teeth missing prior to the member's eligibility under the dental plan.

Other Expenses and Fees

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

Miscellaneous Exclusions

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

Choice of Provider

You may choose any licensed dental care provider for services.

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

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

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

To find a participating provider, visit the claims administrator's website at bluecrossmn.com/associate or call the toll-free number on your member ID card.

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

Payment of Benefits

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

The claims administrator is not liable to pay benefits for any services started prior to a member's effective date of coverage. Procedures started prior to your and/or your enrolled dependent(s) effective date are the liability of you and/or your dependent(s).

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

Participating Provider

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

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

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

Nonparticipating Provider

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

The claims administrator will either send payment for covered services to you or the claims administrator may choose to pay the nonparticipating provider. You will still be notified of the services covered, the claims administrator's payment and any out-of-pocket expenses.

When the claims administrator pays the provider, the claims administrator has met its obligation under the benefit booklet. You may not assign your right, if any, to commence legal proceedings against the claims administrator.

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

Who is Eligible for Coverage and How to Enroll

You are eligible for coverage under the plan if you are an:

- Eligible Associate,
- Spouse/domestic partner of an Eligible Associate, or
- Dependent child of an Eligible Associate, and you timely enroll and timely pay all required contributions for coverage.

The plan administrator may require, from time to time, that an eligible associate provide proof or certification that a dependent meets the requirements for coverage under the plan. If the eligible associate does not provide proof or certification to the satisfaction of the plan administrator, then coverage of the dependent may be terminated (or if applicable, their enrollment in coverage may be denied).

A dependent may not be enrolled for coverage unless the eligible associate is also enrolled for coverage, except as explained under the “Continuation of Coverage” section below.

NOTE: If you, your spouse/domestic partner, and/or dependent are associates of the employer, you may be covered as either an associate or as a dependent, but not as both. Your eligible dependent children may be covered under either parent's coverage, but not both.

Eligible Associates

This plan covers only those associates who work in the United States or its Territories. Associates who work and reside in foreign countries are not eligible for coverage. Associates who are U.S. citizens or permanent residents of the U.S. working outside of the U.S. on a temporary basis are eligible.

You are eligible to participate in the Plan if you are an “Eligible Associate”. You are an “Eligible Associate” if you are:

1. employed by Blue Cross and Blue Shield of Minnesota or one of its subsidiaries that has adopted the Plan (“Employer”);
2. classified by your Employer as (a) a “full-time Employee” (this is an Employee who is regularly scheduled to work at least 30 hours per week), or (b) a “part-time Employee” who is regularly scheduled to work at least 20 hours per week; and
3. not excluded from the definition of Eligible Associate.

Not Eligible Associate (Excluded)

You are not an Eligible Associate (you are excluded from the definition of Eligible Associate) if you are (1) classified by the Employer as a part-time Employee regularly scheduled to work less than 20 hours per week, a leased Employee, or independent contractor; or non-Regular associate; or covered by a collective bargaining agreement or contract that does not provide for your participation, or (2) employed by a Blue Cross and Blue Shield of Minnesota subsidiary or other affiliate that has not adopted the Plan.

Associates of Acquired Businesses

The Plan Administrator may apply special eligibility and entry date rules for Associates of a business acquired by Blue Cross and Blue Shield of Minnesota. You would be notified by the Plan Administrator if this applies to you.

Spouse/Domestic Partner

1. Legally married spouse of the Eligible Associate.
2. Domestic partner of the Eligible Associate, if all the following criteria are met:
    a. For at least one year prior, have chosen to share one another’s lives in an intimate and committed relationship of mutual caring
    b. Maintain the same principal place of residence and intend to do so in the future
    c. Agree to be responsible for each other’s basic living expenses in the event that either of you is unable to provide such expenses
    d. Are both 18 or older
    e. Are not married nor legally separated
    f. Are not related by blood to such a degree that would prevent marriage in the state in which both partners reside

If your partner and their child(ren) will not be treated as your dependents when you file your taxes, imputed income applies. Imputed income is the fair market value of the additional benefit coverage for your domestic partner and/or their child(ren) and, under IRS regulations it is treated as taxable income to the associate separate from, and in addition to, your bi-weekly plan cost. Imputed income is subject to both federal and FICA taxes and will be included on your Form W-2. For example, you will be taxed on the difference between the associate/domestic partner/child(ren) company contribution and the associate only contribution each pay day the coverage is in effect.

Dependent Children Up to age 26

1. Your children (through birth, adoption, foster or legal guardianship)
2. Your stepchildren or children of your qualified domestic partner
3. Grandchildren who live with you or your spouse, are financially dependent upon you or your spouse and for whom you or your spouse/domestic partner have legal custody or have been appointed legal guardian
4. Children awarded coverage because of a Qualified Medical Child Support Order (QMCSO), as defined in ERISA §609(a)

A dependent child's coverage automatically terminates, and all benefits hereunder cease at the end of the month the dependent reaches the limiting age (unless coverage is extended as explained under "Disabled Dependent Children" below) or otherwise ceases to be a dependent as defined above, whether or not notice to terminate is received.

Disabled Dependent Children

Disabled dependent children who reach the limiting age while covered under this Plan if all of the following apply:

a. chiefly dependent upon the Eligible Associate for support and maintenance;

b. incapable of self-sustaining employment because of developmental disability, mental illness or disorder or physical disability; and

c. for whom application for extended coverage as a disabled dependent child is made within 31 days after reaching the age 26 limit. After this initial proof, the claims administrator may request proof again two (2) years later, and each year thereafter; and

d. must have become disabled prior to reaching limiting age.

NOTE: For non-qualified dependents, such as domestic partners and their children not filed on your taxes, a portion of the employer contribution to the overall cost of the health insurance plan must be reported to the IRS as taxable income,

Initial Enrollment

New Associates

An Eligible Associate may enroll in this Plan as of the first day of their employment (or, if later, the date they first become an Eligible Associate) if the Eligible Associate submits their enrollment request within 30 days of the hire date (or the date they first become an Eligible Associate). The Eligible Associate may also enroll any eligible dependent at such time. If an Eligible Associate fails to enroll themselves, or any eligible dependent, in the plan when first eligible, they may not enroll for coverage until the next open enrollment period unless a special enrollment period, as explained below, applies. To enroll for coverage complete the benefit event in Workday.

Open Enrollment Periods

Each year, typically in the fall, the plan administrator will offer an open enrollment period during which you can (1) continue your existing coverage, (2) enroll yourself or eligible dependents if not enrolled, or (3) drop coverage or remove an enrolled dependent. These elections will become effective on the first day of the following plan year. Your enrollment decisions will remain in effect for the entirety of the next plan year (provided you and your enrolled dependents remain eligible for coverage) and may only be changed if you have a special enrollment period.

Special Enrollment Periods

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

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

To change coverage for yourself or your dependents due to a special enrollment event, complete a qualifying life event in Workday.

Adding a Spouse/Domestic Partner and/or Stepchild(ren)/Domestic Partner's Child(ren) due to Marriage or Attestation of Domestic Partnership

If the plan administrator receives the enrollment event request within 60 days of the date of marriage or attestation of satisfaction of the requirements of a domestic partnership, coverage for your spouse/domestic partner and/or stepchild(ren)/domestic partner's child(ren) starts on the date of marriage or attestation of satisfaction of the domestic partnership requirements.

In the event that enrollment event request is not made within 60 days, the Eligible Associate may not enroll a spouse/domestic partner and/or their eligible children until the next open enrollment period unless a special enrollment period, as explained below, applies.

Adding Child(ren) due to Birth, Placement for Adoption/Foster care or Court order

If a child becomes eligible (such as due to birth, adoption, placement for adoption, or being placed with the Eligible Associate in foster care) after the Eligible Associate has enrolled, then such child may be added within 60 days following the event, and coverage will be effective as of the date of the event. In the event that enrollment event is not made within 60 days, the Eligible Associate may not enroll the child until the next open enrollment period unless a special enrollment period, as explained below, applies.

If coverage is sought pursuant to a qualified medical child support order, coverage may be effective as of the date of the court order.

Continuing Coverage for Disabled Dependents

To be eligible for dependent coverage, the Eligible Associate must apply for continued coverage within 30 days after your dependent turns age 26. Coverage for your disabled dependent will be reinstated retroactive to their 26th birthday.

Loss of Other Coverage or Eligibility for Other Coverage (excluding continuation coverage).

If an Eligible Associate and/or dependents waived this coverage because they were covered under another group plan, and is no longer covered under the other plan because:

i. COBRA continuation has been exhausted (not due to failure to pay premium or for cause),
ii. termination of employment or reduction in hours
iii. death of the primary covered individual,
iv. he/she/they is no longer eligible for the plan due to a divorce or legal separation,
v. he/she/they is no longer eligible for the plan due to a domestic partnership ending,
vi. loss of dependent status,
vii. all employer contributions towards the coverage were terminated, or
viii. the individual no longer lives or works in the service area.

The Eligible Associate and/or dependents are eligible to enroll under a Special Enrollment Period. The Eligible Associate must apply for continued coverage 60 days after the termination of other coverage or employer contribution. Coverage will be effective the day after the termination of other coverage.

Gain of Other Coverage

If an Eligible Associate and/or dependents gained other coverage and needs to drop coverage in this plan for themselves or their dependents the Eligible Associate must request a change in coverage through Workday within 60 of gaining the other coverage. Coverage will end effective the day prior to the start of other coverage.

Medicaid and Children's Health Insurance Program (CHIP) Participants

If an Eligible Associate and/or dependents are covered under a state Medicaid Plan or a state CHIP (if applicable) and that coverage is terminated as a result of loss of eligibility, then such associate may request enrollment in the plan on behalf of him/herself and/or eligible dependents. Such request shall be submitted through Workday within 60 days after the Eligible Associate's and/or his/her dependent's coverage ends under such state plans.

If an Eligible Associate and/or his/her eligible dependents become eligible for premium assistance under a state Medicaid Plan or a state CHIP (if applicable), then such associate may request enrollment in this plan on behalf of him/herself and/or such eligible dependents. Such request shall be submitted through Workday no later than 60 calendar days after the date the Eligible Associate and/or his/her eligible dependents are determined to be eligible for premium assistance under such state plans.

Changes in Status

For the plan to administer consistent coverage for you and your dependents, you must keep your Associate Benefit Department informed about any address changes or changes in family status (births, adoptions, deaths, marriages, domestic partnership beginnings, divorces, domestic partnership ends, etc.) that may affect your coverage. You should notify the plan administrator within 30 days if any dependent ceases to qualify as a dependent so that they can be removed from coverage. If you do not notify the plan administrator when a dependent loses eligibility, you may be liable for any claims paid under the plan after their loss of eligibility (unless they timely elect and pay for COBRA coverage).

Leave of Absence or Layoff

Your participation in the plan during a leave of absence depends on whether it is paid or unpaid and the type of leave (e.g., FMLA). Please contact the plan administrator for information.

Upon your return to work following a leave of absence or layoff that continued beyond the period of your coverage, your Employer may, in some cases, allow you to resume your coverage under the plan. The plan administrator will notify you if special leave of absence coverage rules applies to you.

If you are eligible, you may take up to 12 weeks of unpaid leave under FMLA in a 12-month period. Your health care benefits will continue, and you will be responsible to pay the applicable premiums while on any paid portion of FMLA leave. Such coverage will continue until the earlier of the expiration of such leave or the date you notify your employer that you do not intend to return to work. When you return to work, you are responsible for any missed contributions and any contributions you owe will be deducted from your pay. The company may recover contributions it paid to maintain coverage for an employee who fails to return to work from FMLA leave.

If you do not return after an approved leave of absence, you may be eligible to continue coverage, provided that you elect to continue coverage under COBRA. If you return to work immediately following an approved FMLA leave and did not continue coverage for some or all of your leave, then your coverage will be automatically reinstated upon your return to employment.

Rehires

If you terminate employment and are rehired as an Eligible Associate, you will be treated as a new hire and must enroll in the plan within 30 days of rehire date (or, if later, within 30 days after you become an Eligible Associate) as described under "Initial Enrollment" above. If you choose to enroll in the same plan within the plan year, accumulated deductible and maximum amounts will be maintained if rehired within the same plan year.

Termination of Coverage

Termination of Your Coverage

Coverage ends on the latest of the following dates:

1. For you and your dependents, the date on which the plan terminates.
2. For you and your dependents, the last day of the month:
    a. you are no longer eligible, including as a result of your termination of employment, reduction in hours or for certain types of leaves of absence.
    b. you request that coverage be terminated because you have a qualifying life event in which you have enrolled in coverage through another party, such as your spouse's employer.
3. For the spouse/domestic partner:
    a. For the spouse/domestic partner, the date the spouse/domestic partner is no longer eligible for coverage. This is the last day of the month that the associate and spouse/domestic partner divorce or legally separate or terminate their civil union, or the domestic partner criteria is no longer meets the domestic partner requirements.
    b. you request coverage be terminated for the spouse/domestic partner because such individual has or will obtain coverage under another plan, such as if they become employed and their new employer provides coverage.
4. For a dependent child, the date the dependent child is no longer eligible for coverage. This is the last day of the month in which:
    a. a covered stepchild is no longer eligible because the associate and spouse divorce.
    b. a covered dependent is no longer eligible because the associate and the domestic partner terminate their domestic partnership.
    c. a covered dependent is no longer eligible because the associate and civil union spouse terminate their civil union.
    d. the dependent child reaches the dependent child limiting age.
    e. the disabled dependent is no longer eligible.
    f. any other event occurs that causes a loss of eligibility, such as termination of a foster relationship.

    You may also request that your coverage be terminated for a dependent child because such individual has or will obtain coverage under another plan, such as if they become employed and their new employer provides coverage.
5. The date we determine an associate or dependent committed fraud or misrepresentation with respect to eligibility or any other material fact subject to the "Termination for Fraudulent Practices" provision.

Benefits After Coverage Terminates

The claims administrator is not liable to pay any benefits for covered services which are started after you or your dependent(s) coverage has been terminated.

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

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

Termination for Fraudulent Practices

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

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

Continuation of Coverage

A federal law, known as “COBRA,” allows you or a dependent to continue coverage for a period of time after the date your coverage otherwise would have terminated as explained in this section.

Type of Coverage

Generally, continuation coverage is the same coverage that you or your dependent had on the day before the qualifying event. If you timely elect and pay for continuation coverage, then during the continuation period you generally have the same rights under this plan as active associates or their dependents as noted under “Annual Open Enrollment” and “Special Enrollment.”

Qualifying Events

You or your covered dependents may continue plan coverage if coverage would otherwise end because of one of the qualifying events listed below, and any required notice is timely provided as explained under “Continuation Notice Obligations” below. In general, you and your eligible dependents must be covered on the day before the qualifying event in order to continue coverage.

NOTE: Upon a qualifying event, you may have a right to special enrollment in a new plan such as an individual plan or another employer plan. Please consider all of your choices carefully before making an election for COBRA continuation coverage.

Qualifying Event	What does this mean?	Who May Continue	Maximum Continuation Period
Termination of employment	Voluntary or involuntary termination for reasons other than gross misconduct.	Associate and dependent(s).	a. 18 months from the 1st of the month following the event
Reduction in hours or loss of eligibility	Due to lay-off, leave of absence, strike, lockout, reduction in hours to less than 20 hours per week.		
Death of associate		Dependent(s).	a. 36 months from the 1st of the month following the event,
Divorce or legal separation or termination of domestic partnership	a. Spouse/ex-spouse or domestic partner/ex-domestic partner was covered on the day before the entry of the valid decree of dissolution of marriage or domestic partnership ends. b. If coverage for spouse was terminated in anticipation of the divorce or legal separation, a later divorce or legal separation is considered a qualifying event. This is the sole situation in which an individual need not be covered under the plan prior to the date of the qualifying event (the divorce) and still be offered continuation coverage.	Spouse/ex-spouse or domestic partner/ex-domestic partner and any dependent children who lose coverage.	a. 36 months from the 1st of the month following the event

Qualifying Event	What does this mean?	Who May Continue	Maximum Continuation Period
Dependent child is no longer eligible	See eligibility requirements as explained in "Eligible Dependents" section.	Dependent child.	a. 36 months from the 1st of the month following the event

Qualifying Event Extensions

If the qualifying event is a termination of employment or reduction in hours, loss of eligibility, the maximum coverage period of 18 months can be extended in certain circumstances.

Total Disability of Dependent(s)

1. You have continuation coverage because the associate was terminated from employment or had a reduction of hours and
2. The Social Security Administration (SSA) has determined that a dependent covered under the initial continuation coverage is disabled at any time during the first 60 days of continuation,
3. The disability continues through the end of the initial 18 month continuation period, and
4. The individual timely notifies the plan administrator of the SSA's determination as explained under "Continuation Notice Obligations" below.

Dependents covered under the initial continuation coverage may extend coverage for a maximum period of 29 months from the date the original qualified event (associate terminates employment or has a reduction in hours).

Second Qualifying Event

1. You have continuation coverage because the associate was terminated or had a reduction of hours, and
2. A second qualifying event occurs prior to the end of the original 18-month continuation period or 29-month disability extension, and
3. The second qualifying event is one that has at least a 36-month continuation period, and
4. Timely notification of the second qualifying event is made, as described under "Continuation Notice Obligations" below.

Dependents covered under the initial continuation coverage may extend coverage for a maximum period of 36 months from the date of the initial event.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

This continuation right runs concurrently with your continuation right under COBRA when you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty, the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States.

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

Continuation Notice Obligations

In some cases, you or a dependent must provide timely notice to the employer in order to be able to elect COBRA continuation coverage. Notice must be provided via Workday through a qualifying life event. If notice is not timely provided, then COBRA continuation coverage will not be offered. Please review the chart below to understand when the associate or dependent must submit a benefit event in Workday.

Notices for	Associate/Dependent
Coverage termination due to: a. Termination of employment, or b. Reduction in the hours, or c. Loss of eligibility	Notice required not required

Notices for	Associate/Dependent
Coverage termination due to: a. Divorce or legal separation, b. Domestic Partnership ends, or c. Dependent Child is no longer eligible.	a. Notice must be provided to employer within 60 days of the event. b. Notice must be provided to employer within 60 days after a later divorce or legal separation or domestic partnership ends when coverage was earlier terminated in anticipation of the divorce or legal separation or domestic partner dissolution.
Extension of continuation due to: a. Disability determination, or b. Second qualifying event.	Notice must be provided: a. to employer within 60 days of the disability determination (receipt of SSA disability determination letter) or new event, and b. before the end of the initial 18-month.

Continuation Coverage Elections

If COBRA continuation coverage is available, then the employer will send COBRA election information to the qualified beneficiary. The qualified beneficiary must make their COBRA election within 60 days of the qualifying event or the date of the qualifying notice, whichever is later.

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

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

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

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

Termination of Continuation Coverage Before the End of Maximum Coverage Period

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

1. The employer no longer provides group dental coverage to any of its associates.
2. The premium for continuation coverage is not paid when due.
3. If during the 11-month extension due to disability the SSA makes the final determination that the qualified beneficiary is no longer disabled. You must notify the employer within 30 days of the final determination.
4. The occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to any covered associates or their dependents whether or not they are on continuation coverage.
5. Voluntarily canceling your continuation coverage.

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

Continuation Premiums

In order to continue coverage under COBRA, you are required to timely pay the premiums for such coverage. The COBRA premiums can be up to the group rate (the combination of employer plus associate costs of coverage) plus a two (2) percent administration fee.

In the event of extended coverage due to a dependent's disability, the premiums for continuation for the associate and dependents can be up to 150 percent of the group rate for months 19-29.

All premiums are paid directly to the employer (or the employer's third party COBRA administrator).

Coordination of Benefits

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

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

Coordination of Benefits Definition

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

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

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

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

Primary Plan – The plan that determines its benefits first and without considering the other plan's benefits. A plan that does not include a COB provision may not take the benefits of another plan into account when it determines its benefits.

Secondary Plan – The plan that determines its benefits after those of the other plan (primary plan). Benefits may be reduced because of the other plan's (primary plan's) benefits.

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

COB Determination Rules

In order to determine which plan is primary, this plan will use the following rules in order. If none of these rules apply, then the plan which has continuously covered the member for a longer period of time will be primary. In all cases, the plan covering an individual as a COBRA qualified beneficiary will be secondary to a plan covering that individual as a member or a dependent.

COB for You and Your Dependent(s)

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

COB for Your Dependent Children

1. Birthday Rule

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

2. Dependent child and parents are separated or divorced

a. The plan of the parent with custody of the child will be first.
b. Then the plan of the spouse of the parent with the custody of the child.
c. Then the plan of the parent not having custody of the child.
d. If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be secondary.
e. If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child will follow the birthday rule.

COB for Active/Inactive Member

1. For actively employed members and their spouses/domestic partners over the age of 65 who are covered by Medicare, the plan will be primary.
2. If another plan does not have this rule, then this rule will be ignored.

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. 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 disclosure of information without the consent of the member or member's representative. Each person claiming benefits under this plan must give any facts needed to pay the claim.

Facility of Payment

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

The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the services prepaid by the claims administrator.

Right of Recovery

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

1. Persons the claims administrator has paid or for whom the claims administrator has paid;
2. Insurance companies; and
3. Other organizations.

Any payment made or amount paid includes the reasonable cash value of any benefits provided in the form of services. You are required to assist the claims administrator to implement this section.

Reimbursement and Subrogation

This plan maintains both a right of reimbursement and a separate right of subrogation**. As an express condition of your participation in this plan, you agree that the plan has the subrogation rights and reimbursement rights explained below.**

The Plan's Right of Subrogation

If you or your dependents receive benefits under this plan arising out of an illness or injury for which a responsible party is or may be liable, this plan shall be subrogated to your claims and/or your dependents' claims against the responsible party.

Obligation to Reimburse the Plan

You are obligated to reimburse the plan in accordance with this provision if the plan pays any benefits and you, or your dependent(s), heirs, guardians, executors, trustees, or other representatives recover compensation or receive payment related in any manner to an illness, accident or condition, regardless of how characterized, from a responsible party, a responsible party's insurer or your own (first party) insurer. You must reimburse the plan for 100 percent of benefits paid by the plan before you or your dependents, including minors, are entitled to keep or benefit by any payment, regardless of whether you or your dependent has been fully compensated and regardless of whether medical or dental expenses are itemized in a settlement agreement, award or verdict.

You are also obligated to reimburse the plan from amounts you receive as compensation or other payments as a result of settlements or judgments, including amounts designated as compensation for pain and suffering, non-economic damages and/or general damages. The plan is entitled to recover from any plan, person, entity, insurer (first party or third party), and/or insurance policy (including no-fault automobile insurance, an uninsured motorist's plan, a homeowner's plan, a renter's plan, or a liability plan) that is or may be liable for:

1. the accident, injury, sickness, or condition that resulted in benefits being paid under the plan; and/or
2. the medical, dental, and other expenses incurred by you or your dependents for which benefits are paid or will be paid under the plan.

Until the plan has been fully reimbursed, all payments received by you, your dependents, heirs, guardians, executors, trustees, attorneys or other representatives in relation to a judgment or settlement of any claim of yours or of your dependent(s) that arises from the same event as to which payment by the plan is related shall be held by the recipient in constructive trust for the satisfaction of the plan's subrogation and/or reimbursement claims.

Complying with these obligations to reimburse the plan is a condition of your continued coverage and the continued coverage of your dependents.

Duty to Cooperate

You, your dependents, your attorneys or other representatives must cooperate to secure enforcement of these subrogation and reimbursement rights. This means you must take no action - including, but not limited to, settlement of any claim - that prejudices or may prejudice these subrogation or reimbursement rights. As soon as you become aware of any claims for which the plan is or may be entitled to assert subrogation and reimbursement rights, you must inform the plan by providing written notification to the claims administrator of:

1. the potential or actual claims that you and your dependents have or may have;
2. the identity of any and all parties who are or may be liable; and
3. the date and nature of the accident, injury, sickness or condition for which the plan has or will pay benefits and for which it may be entitled to subrogate or be reimbursed.

You and your dependents must provide this information as soon as possible, and in any event, before the earlier of the date on which you, your dependents, your attorneys or other representatives:

1. agree to any settlement or compromise of such claims; or
2. bring a legal action against any other party.

You have a continuing obligation to notify the claims administrator of information about your efforts or your dependents' efforts to recover compensation.

In addition, as part of your duty to cooperate, **you and your dependents must complete and sign all forms and papers, which may include a Reimbursement Agreement,** as required by the plan and provide any other information required by the plan. A violation of the Reimbursement Agreement is considered a violation of the terms of the plan.

The plan may take such action as may be necessary and appropriate to preserve its rights, including bringing suit in your name or intervening in any lawsuit involving you or your dependent(s) following injury. The plan may require you to assign your rights of recovery to the extent of benefits provided under the plan. The plan may initiate any suit against you or your dependent(s) or your legal representatives to enforce the terms of this plan. The plan may commence a court proceeding with respect to this provision in any court of competent jurisdiction that the plan may elect.

Attorney's Fees and Other Expenses You Incur

The plan will not be responsible for any attorneys' fees or costs incurred by you or your dependents in connection with any claim or lawsuit against any party, unless, prior to incurring such fees or costs, the plan in the exercise of its sole and complete discretion has agreed in writing to pay all or some portion of fees or costs. The common fund doctrine or attorneys' fund doctrine shall not govern the allocation of attorney's fees incurred by you or your dependents in connection with any claim or lawsuit against any other party and no portion of such fees or costs shall be an offset against the plan's right to reimbursement without the express written consent of the claims administrator.

The plan administrator may delegate any or all functions or decisions it may have under this Reimbursement and Subrogation section to the claims administrator.

What May Happen to Your Future Benefits

If you or your dependent(s) obtain a settlement, judgment, or other recovery from any person or entity, including your own automobile or liability carrier, without first reimbursing the plan, the plan in the exercise of its sole and complete discretion, may determine that you, your dependents, your attorneys or other representatives have failed to cooperate with the plan's subrogation and reimbursement efforts. If the plan determines that you have failed to cooperate the plan may decline to pay for any additional care or treatment for you or your dependent(s) until the plan is reimbursed in accordance with the plan terms or until the additional care or treatment exceeds any amounts that you or your dependent(s) recover. This right to offset will not be limited to benefits for the insured person or to treatment related to the injury, but will apply to all benefits otherwise payable under the plan for you and your dependents.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the claims administrator shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Release of Records

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

The claims administrator may need this information to:

1. Process claims.
2. Conduct Utilization Review.
3. Conduct care management and quality improvement activities.
4. Conduct reimbursement and subrogation review.
5. Conduct other dental plan activities as permitted by law.

The claims administrator keeps this information confidential, but may release it if you authorize release, or if state or federal law permits or requires release without your authorization.

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

Claims Process

Notice of Claim

Written notice of claim must be given to the claims administrator within 20 days after the date a covered service or supply is obtained (this is referred to as the “claim date”), or as soon thereafter as is reasonably possible.

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

If you obtain a service or supply from a participating provider, they will file a claim on your behalf. If you obtain a service or supply from a nonparticipating provider, it is your responsibility to ensure that a claim is timely filed.

Making a Claim for Benefits

If you are responsible to make a claim, then upon receipt of a notice of claim, the claims administrator will provide you with forms that you should complete and return in order to have your claim processed under the plan. These forms must be returned within 90 days after the claim date. Failure to file the claim within the 90-day time required shall not invalidate nor reduce any claim if it was not reasonably possible to make the claim within such time, provided the claim is filed as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the claim date.

If such forms are not furnished before the expiration of 15 days after the claims administrator received notice of any claim under the benefit booklet, the person making such claim shall be deemed to have complied with the requirements of the benefit booklet as to filing a timely and complete claim.

The claims administrator’s acknowledgment of the receipt of notice given or the furnishing of forms for filing claims, or the acceptance of a claim, or the investigation of any claim thereunder shall not operate as an approval of the claim or a waiver of any of the rights of the claims administrator in defense of any claim arising under such benefit booklet.

Time Payment of Claims

All benefits payable under this benefit booklet will be paid promptly after the claims administrator processes the claim. Claims will not be processed unless the claims administrator has received all documentation or information that the claims administrator may require to process the claim.

Payment of Claims

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

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

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

Right of Examination

The claims administrator has the right to ask you to be examined by a dental care provider during the review of any claim. The claims administrator will choose the dental care provider and pay for the exam whenever this is requested.

Review of a Benefit Determination

If your claim is denied in whole or part, you will receive a written notice with information about the denial and the reason the claim was not paid.

If you are not satisfied with a benefit determination or payment, please contact the customer service department at the toll-free telephone number listed in the "Questions?" section or on your member ID card. The claims administrator will try to resolve your oral complaint as quickly as possible.

However, if after speaking with a customer service representative, the resolution of your oral complaint is wholly or partially adverse to you or not resolved to your satisfaction you may submit an appeal in writing.

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

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

Appeal Process

If the claims administrator decides a claim that is wholly or partially adverse to you, and you wish to appeal, you are required to submit an appeal. You have 180 days from the date you received notice of the adverse benefit determination to appeal the decision. You can call the number on the back of your ID card or write the claims administrator with your appeal. You or anyone you authorize to act on your behalf may submit your appeal in writing.

The request for an appeal should include:

1. the member's name, identification number, and group number;
2. the dental claim for which coverage was denied;
3. a copy of the denial;
4. the reason why you or your dental care provider believes the service should be covered; and
5. any available dental information you believe will be helpful to the decision.

Your appeal must state all reasons and arguments in support of the appeal, and you must submit all evidence in support of your appeal, unless that evidence is already in our possession.

Send your Appeal to:
Dental Customer Service
Appeals Unit
P.O. Box 69420
Harrisburg, PA 17106-9420

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

The claims administrator will notify you that the claims administrator has received your written appeal. The claims administrator will inform you of our decision and the reasons for the decision within 60 days of receiving your appeal and all necessary information. If the claims administrator needs specific information, including medical or dental records, to complete our review and you or your health care/dental care professional does not release the requested information your claim may be denied. You have the right to review the information that the claims administrator relied on in the course of the appeal.

To the extent your plan is covered by ERISA, after you have exhausted all appeals, you may file a civil action under section 502(a) of ERISA within one year after your appeal is denied.

General Information

Plan Administration

Plan Administrator

The general administration of the plan and the duty to carry out its provisions is vested in the employer. The employer may delegate its authority to carry out administrative functions to one or more persons, including associates and agents of the employer, and may from time to time revoke such authority and delegate it to another person. Notwithstanding any designation or delegation of final authority with respect to claims, the plan administrator generally has final authority to administer the plan.

Powers and Duties of the Plan Administrator

The plan administrator will have the discretionary authority to control and manage the operation and administration of the plan. This will include all rights and powers necessary or convenient to carry out its functions as plan administrator. Without limiting that general authority, the plan administrator will have the express discretionary authority to:

1. construe and interpret the provisions of the plan and decide all questions of eligibility;
2. prescribe forms, procedures, policies, and rules to be followed by you and other persons claiming benefits under the plan;
3. prepare and distribute information to you explaining the plan;
4. receive from you and any other parties the necessary information for the proper administration of eligibility requirements under the plan;
5. receive, review, and maintain reports of the financial condition and receipts and disbursements of the plan; and
6. to retain such actuaries, accountants, consultants, third party administration service providers, legal counsel, or other specialists, as it may deem appropriate or necessary for the effective administration of the plan.

Actions of the Plan Administrator

The plan administrator may adopt such rules as it deems necessary, desirable, or appropriate. All determinations, interpretations, rules, and decisions of the plan administrator shall be made in its sole discretion and shall be conclusive and binding upon all persons having or claiming to have any interest or right under the plan, except with respect to claim determinations where final authority has been delegated to the claims administrator. All rules and decisions of the plan administrator will be uniformly and consistently applied so that all individuals who are similarly situated will receive substantially the same treatment.

The plan administrator or the employer may contract with one (1) or more service agents, including the claims administrator, to assist in the handling of claims under the plan and/or to provide advice and assistance in the general administration of the plan. Such service agent(s) may also be given the authority to make payments of benefits under the plan on behalf of and subject to the authority of the plan administrator. Such service agent(s) may also be given the authority to determine claims in accordance with procedures, policies, interpretations, rules, or practices made, adopted, or approved by the plan administrator.

Termination or Changes to the Plan

No agent can legally change the plan or waive any of its terms.

The employer reserves the power at any time and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the code or ERISA) to terminate, modify or amend, in whole or in part, any or all provisions of the plan, provided, however that no modification or amendment shall divest an associate of a right to those benefits to which he or she or they have become entitled under the plan. Any amendment to this plan may be affected by a written resolution or other written action adopted by the plan administrator, including by providing revised benefit booklets.

Funding

This plan is a self-insured plan funded by contributions from the employer and/or associates. Funds for benefit payments are provided by the employer according to the terms of its agreement with the claims administrator. Your contributions toward the cost of coverage under the plan will be determined by the employer each year; your coverage under the plan is expressly conditioned on your timely payment of the required contributions.

Controlling Law

Except as they may be subject to federal law, including ERISA, any questions, claims, disputes, or litigation concerning or arising from the plan will be governed by the laws of the State of Minnesota.

Payments Made in Error

Payments made in error or overpayments may be recovered by the claims administrator as provided by law or equity. This includes the right to offset the amount of the overpayment from any future benefits to be paid to or on behalf of you or your eligible dependents. Payment made for a specific service or erroneous payment shall not make the claims administrator or the plan administrator liable for further payment for the same service.

No Third-Party Beneficiaries

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

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

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

Time Periods

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

Privacy of Protected Health Information

Protected Health Information (PHI) is individually identifiable information created or received by a health care provider or a health care plan, including this plan. This information is related to your past, present, or future health or the payment for such health care. PHI includes demographic information that either identifies you or provides a reasonable basis to believe that it could be used to identify you.

Restrictions on the Use and Disclosure of Protected Health Information

The employer may not use or disclose PHI for employment-related actions or decisions. The employer may only use or further disclose PHI as permitted or required by law and will report any use or disclosure of PHI that is inconsistent with the allowed uses and disclosures.

Separation Between the Employer and the Plan

The associates, classes of associates or other workforce members below will have access to PHI only to perform the plan administration functions that the employer provides for the plan. The following may be given access to PHI: plan administrator. This list includes every associate or class of associates or other workforce members under the control of the employer who may receive PHI relating to the ordinary course of business.

The associates, classes of associates or other workforce members identified above will be subject to disciplinary action and sanctions for any use or disclosure of PHI that is in violation of these provisions. The employer will promptly report such instances to the plan and will cooperate to correct the problem. The employer will impose appropriate disciplinary actions on each associate or workforce member and will reduce any harmful effects of the violation.

Availability of Privacy Notice

The Blue Cross and Blue Shield of Minnesota Welfare Benefit Plan (the “Plan”) has issued a Health Plan Privacy Notice that describes how the Plan uses and discloses protected health information (PHI). You can obtain a copy of the Blue Cross and Blue Shield of Minnesota Welfare Benefit Plan Privacy Notice upon your written request to the Human Resources Department, at the following address:

Blue Cross and Blue Shield of Minnesota, Human Resources
3400 Yankee Drive
Eagan, MN 55121

If you have any questions, please contact the Blue Cross and Blue Shield of Minnesota Human Resources Office at benefits@bluecrossmn.com.

Terms You Should Know

Benefit Booklet – This document, including schedules, addenda and/or endorsements, if any, which are attached to the benefit booklet and describe the dental coverage available under the plan.

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

Claims Administrator – Blue Cross and Blue Shield of Minnesota (Blue Cross).

Coinsurance – Those remaining percentages or dollar amounts of the maximum allowable charge or the usual, customary and reasonable allowance for a covered service that are the responsibility of the member after the claims administrator pays the percentages or dollar amounts shown on the "Schedule of Benefits for a Covered Service."

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

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

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

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

Effective Date – The date on which the benefit booklet begins or the date on which coverage for a member begins.

Enrollment Period – The period that an eligible associate may enroll for coverage under the plan.

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

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

Limiting Age -– The age for a dependent child defined as when a dependent child reaches age 26.

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

Member – An eligible individual who is enrolled for coverage in the plan.

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

Nonparticipating Provider(s) – A dental care provider who has not contracted with the claims administrator to limit his/her charges to you and/or dependent(s).

Oral Evaluations: Detailed Problem Focused Exam – A detailed and extensive problem focused evaluation based on the findings of a comprehensive oral evaluation. Examples of conditions requiring this type of evaluation may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, or conditions requiring multi-disciplinary consultation.

Oral Evaluations: Limited Problem Focused Exams – An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Definitive procedures may be required on the same date as the evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, or acute infections.

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

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

Plan – The plan of benefits established by the plan administrator.

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

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

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

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

Employee Retirement Income Security Act (ERISA) - Statement of Rights

The plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), which provides you with certain rights and protections. ERISA provides that all plan members shall be entitled to:

1. Receive Information About Your Plan and Benefits

a. Examine without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, if any, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

b. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, if any, and copies of the latest annual report (Form 5500 Series) and updated benefit booklet. The plan administrator may make a reasonable charge for the copies.

c. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Continue Group Dental Plan Coverage

Continue dental care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this benefit booklet and the documents governing the plan on the rules governing your continuation coverage rights.

3. Prudent Actions by Plan Fiduciaries

In addition to creating rights for the plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Claims Processing Purposes:
United Concordia Dental
Dental Claims Administrator
PO Box 69449
Harrisburg, PA 17106-9449

For all other Purposes:
Blue Cross and Blue Shield of Minnesota
3400 Yankee Drive
Eagan, MN 55121

4. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide you the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay those costs and fees. If you lose the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

5. Assistance with your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N. W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Important Plan Information

Plan Name:	Blue Cross and Blue Shield of Minnesota Dental Plan
Type of Plan:	A group dental plan (a type of welfare benefits plan that is subject to the provisions of ERISA)
Plan Year:	January 1 through December 31
Plan Number:	501
Funding Medium:	This Plan is funded by contributions from the employer and/or associates. Benefits are not provided under an insurance policy. Funds for benefit payments are provided by the employer according to the terms of its agreement with the claims administrator. Your contribution toward the cost of coverage under the plan will be determined by the employer each year.
Plan Sponsor:	Blue Cross and Blue Shield of Minnesota P.O. Box 64560 St. Paul, MN 55164 (651) 662-1230
Plan Sponsor's Employer Identification Number:	41-0984460
Claims Administrator:	Blue Cross and Blue Shield of Minnesota/United Concordia Dental PO Box 69449 Harrisburg, PA 17106-9449
Plan Administrator:	Blue Cross and Blue Shield of Minnesota P. O. Box 64560 St. Paul, MN 55164 (651) 662-1230
Other Participating Employer(s):	In addition to Blue Cross and Blue Shield of Minnesota, Stella Resources Co. Inc. ("Stella") has adopted the Plan and is a participating employer in the Plan. Stella's Employer Identification Number is 82-2935829.
Agent for Services of Legal Process:	VP of Total Rewards Blue Cross and Blue Shield of Minnesota P. O. Box 64560 St. Paul, MN 55164 (651) 662-1230
Plan Document:	The plan and its attachments, if any, as well as this benefit booklet, constitute the written plan document required by ERISA §402.