SUMMARY OF BENEFITS

DENTAL CARE COVERAGE

Distributed in 2022

Through the University of Minnesota

Dental Care

Be prepared for the possibility of a dental emergency before the need arises by knowing your clinic's procedure for care needed after regular clinic hours.

Name of your clinic: _____

Address: _____

Phone: _____

Dental Plan Group Numbers:

Delta Dental PPO: 6100
Delta Dental Premier: 6090

Benefit Questions

You can reach the Office of Human Resources Contact Center at 612-624-8647 or 1-800-756-2363, select option 1, or email benefits@umn.edu.

Residents/Fellows

Residents/fellows in job codes 9541, 9548, 9549, 9552, 9553, 9554, 9555, 9556, 9559, 9568, 9582, 9583, and 9569 are not covered in this Plan, but are covered in the University of Minnesota Residents/Fellows plan that is available at the following link: https://shb.umn.edu/health-plans/rfi.

Introduction

This Summary of Benefits describes the coverage you have for dental benefits under the University of Minnesota Dental Plan (the Plan) in Plan Year 2022. This booklet describes the eligibility provisions of the Plan, the events that can cause you to lose coverage, your rights to continue coverage when you or your dependents are no longer eligible to participate in the Plan, and your rights to appeal a coverage decision or claim denial.

You will also find a description of the dental benefits covered under the Plan, including comprehensive coverage for most conditions requiring dental diagnosis and treatment, including many preventive and restorative services such as: periodic examinations, X-rays, cleanings, fillings, restorative crowns, root canals, extractions, bridgework, and orthodontic treatment for children. You will also read about the levels of coverage under the Plan and the deductibles and coinsurance that are your responsibility.

The company that administers the claims is Delta Dental of Minnesota.

At open enrollment each year, you have the opportunity to select the dental plan option you want to use for the year. Your cost varies depending on which dental plan option and coverage level you select. This booklet explains which events during the year might allow you to add a dependent or otherwise modify your coverage.

For further information about your dental benefits, you may contact the Office of Human Resources Contact Center or the Administrator at the address below.

Dental Claims Administrator

Delta Dental of Minnesota
500 Washington Avenue South, Suite 2060
Minneapolis, MN 55415

Phone: 651-406-5916
Toll Free: 1-800-553-9536
TTY: 711
Website: www.deltadentalmn.org/uofm

Specific Information About the Plan

Employer: University of Minnesota

Name of the Plan: The Plan shall be known as the University of Minnesota Dental Program that provides dental benefits to certain eligible participants and their dependents.

Address of the Plan: University of Minnesota
Total Compensation
100 Donhowe Building
319 15th Ave. SE
Minneapolis, MN 55455-0103

Plan Year: The Plan Year begins on January 1 and ends on December 31. A Plan Year is 12 months in duration.

Plan Sponsor: Board of Regents
600 McNamara Alumni Center
200 Oak Street SE
Minneapolis, MN 55455-2020

Funding: Claims under the Plan are paid from the assets of the University of Minnesota Dental Program.

Dental Claims Administrator: Delta Dental of Minnesota
500 Washington Avenue South, Suite 2060
Minneapolis, MN 55415

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Plan Availability – Base Plan Map

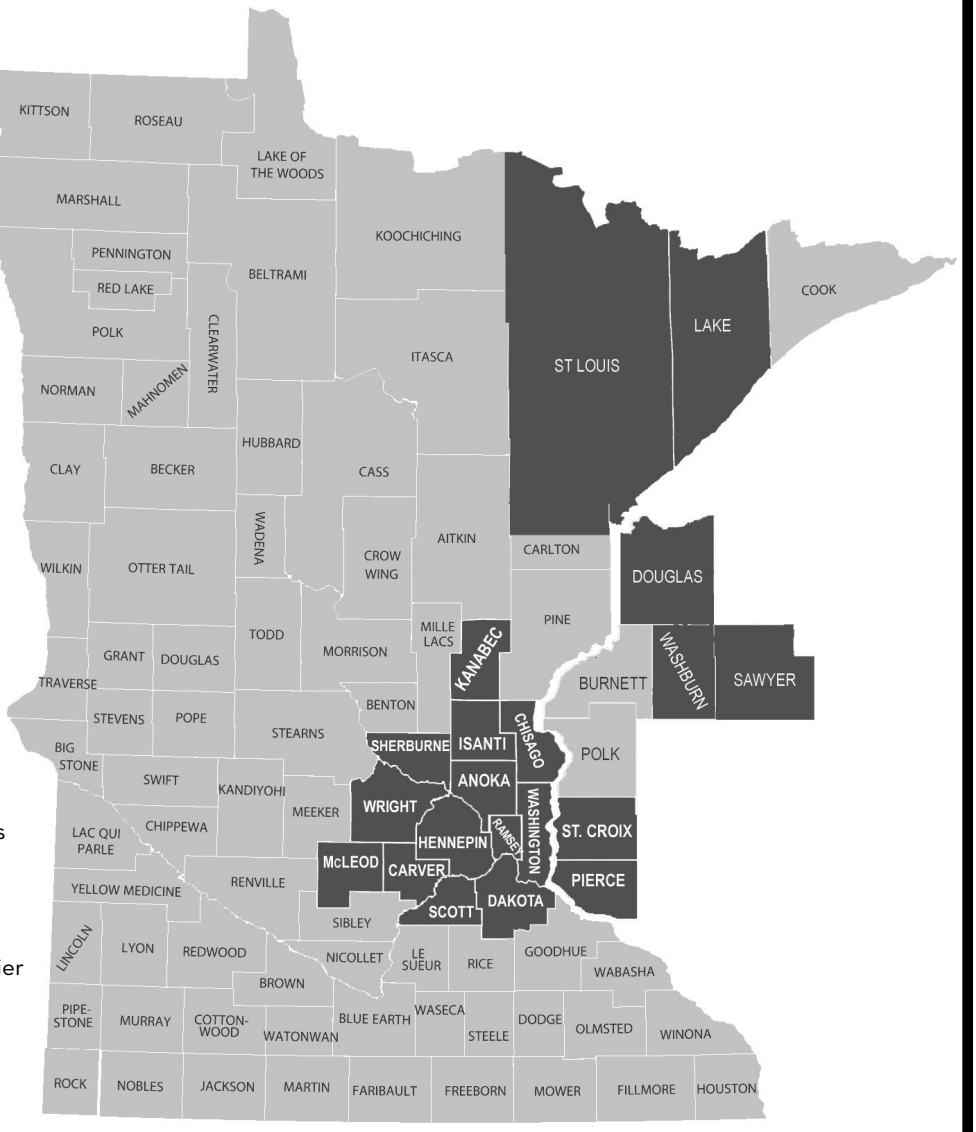
The base plan available to you is determined by your geographic location.

Twin Cities metropolitan area, Duluth area, and northern and southern surrounding counties

Base Plan: Delta Dental PPO

Greater Minnesota

Base Plan: Delta Dental Premier



Delta Dental PPO	Delta Dental Premier
77 Minnesota counties, border communities, and the national Delta Dental PPO network	85 Minnesota counties, border communities, and the national Delta Dental PPO and Delta Dental Premier networks

Dental: Plan Comparison

Plan	DELTA DENTAL PPO In-network coverage only	DELTA DENTAL PREMIER In-network	 Out-of-network
Diagnostic and Preventive Care	100% coverage	100% coverage	50% coverage
Basic Restorative Care	80% coverage Posterior resin restorations (white fillings on back teeth) paid as an amalgam.	80% coverage	After $125 annual deductible, 50% coverage
Major Restorative Care	50% coverage	50% coverage	No coverage
Emergency Services	In-network services provided same as any service; out-of-network services apply $50 deductible then same as any in-network service	Emergency dental services provided same as eligible dental services	After $125 annual deductible, emergency dental services provided same as eligible out-of-network services
Orthodontics	80% coverage	80% coverage	50% coverage

Diagnostic and Preventive Care

- Oral examinations and dental cleanings
- X-rays
- Special periodontics care
- Topical fluoride to age 19
- Space maintainers

Basic Restorative Care

- Fillings (customary restorative materials) is based on plan:
  - Back teeth
    - Amalgam (silver) fillings: Delta Dental PPO
    - Composite (white) fillings: Delta Dental Premier
  - Front teeth
    - Composite (white) fillings: Delta Dental PPO and Premier
- Sealants to age 19
- Extractions and other oral surgery
- Periodontics (gum disease therapy)
- Endodontics (root canal therapy)
- Restorative crowns
- Inlays and onlays
- Repair of a crown

Major Restorative Care

- Fixed or removable bridgework
- Implants as alternative treatment
- Full or partial dentures
- Denture relines or rebases

Orthodontics Coverage

- Limited to dependents up to age 19
- Separate $2,800 lifetime maximum per covered dependent that does not start over if you change plans

1. Introduction to Your Dental Coverage

The University of Minnesota ("Sponsor"), which also serves as sponsor of the plan, has established the University Dental Program ("the Plan") to provide dental benefits for covered contract holders and their covered dependents ("Members"). This Plan is "self-funded," which means that the Sponsor pays the benefit expenses for covered services as claims are incurred. The Plan is described in this Summary of Benefits.

The Sponsor has contracted with Delta Dental to provide networks of dental care providers, claims processing, precertification and other administrative services. However, the Sponsor is solely responsible for payment of your eligible claims.

The Sponsor, by action of an authorized officer or committee, reserves the right to change or terminate the Plan. This includes, but is not limited to, changes to contributions, deductibles, coinsurance, annual maximums, benefits payable, and any other terms or conditions of the Plan. The decision to change the Plan may be due to changes in federal or state laws governing dental benefits, or for any other reason. The Plan may be changed to transfer the Plan's liabilities to another plan or to split this Plan into two or more parts.

The Sponsor has the power to delegate specific duties and responsibilities. Any delegation by the Sponsor may also allow further delegations by such individuals or entities to whom the delegation has been made. Any delegation may be rescinded by the Sponsor at any time. Each person or entity to whom a duty or responsibility has been delegated shall be responsible for only those duties or responsibilities and shall not be responsible for any act or failure to act of any other individual or entity.

A. Claims Administrators — Dental

Delta Dental provides certain administrative services in connection with the Plan. As the external administrator, Delta Dental is referred to as the "Claims Administrator." The Claims Administrator may arrange for additional parties to provide certain administrative services, including claim processing services, customer service, dental management, and complaint resolution assistance.

The Claims Administrator has the discretionary authority to determine a Member's entitlement to benefits under the terms of the Plan, including the authority to determine the amount of payment for claims submitted and to constitute the terms of each Plan. However, the Claims Administrator may not make modifications or amendments to the Plan.

B. Rate Structure

The rate structure for the cost of dental benefits consists of employee-only coverage and two levels of family coverage that are determined by the eligible dependents added to the Plan. The levels are:

- Employee only
- Employee and Children
- Employee and Spouse with or without Children

C. Summary of Benefits

This Summary of Benefits is your description of the University Dental Program. It describes the Plan's benefits and limitations for your dental coverage. Please read this entire summary carefully. Many of its provisions are interrelated; reading just one or two provisions may give you incomplete information regarding your rights and responsibilities under the Plan. Many of the terms used in the Summary of Benefits have special meaning and are specifically defined in the Summary.

Included in this Summary is a Plan Comparison chart that states the amount payable for the covered services. Amendments that are included with this Summary or sent to you at a later date are fully made a part of this Summary of Benefits. This Plan is maintained exclusively for covered participants and their covered dependents. Each Member's rights under the Plan are legally enforceable. The Summary of Benefits is available to view and download on the Employee Benefits website at humanresources.umn.edu/employee-benefits/dental.

1. Introduction to Your Dental Coverage

D. Plan Amendments

The University of Minnesota Total Compensation Office will interpret the Plan and its Summary of Benefits as needed to advise the Claims Administrator on their administration of the Plan. The University of Minnesota may amend the Plan. Plan amendments are incorporated and fully made a part of this Summary and will be communicated to Members during open enrollment.

E. Identification (ID) Card

Your dental Claims Administrator issues identification cards to Members containing coverage information. Please verify the information on the ID card and notify the OHR Contact Center of any errors.

Your name may be abbreviated due to space limitations, but it is important that your identification card is correct or claims may be delayed or temporarily denied.

You must show your dental ID card every time you request dental care services from participating providers. If you do not show your card, the participating provider has no way of knowing you are a Member and may bill you for the services.

F. Provider Directory

To access the most up-to-date information on participating providers, go to Delta Dental's website at www.deltadentalmn.org/uofm. You will find an online search tool and other search tools on the website.

G. Conflict with Existing Law

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

H. Records

Certain facts are needed for plan administration, claims processing, quality assessment, and clinical review team. By enrolling for coverage under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Sponsor or any of its agents or designees at any reasonable time, upon its request, any and all information and records or copies of records relating to the services provided to you.

The Sponsor or its agents or designees will have the right to release any and all records concerning health care services that are necessary to implement and administer the terms of the Plan or for appropriate dental review or quality assessment. The Sponsor and its agents or designees will maintain confidentiality of such information in accordance with existing law. This authorization applies to you and each dependent, regardless of whether each dependent signs the application for enrollment. For information on privacy practices, refer to **10. Notice of Privacy Practices.**

I. Clerical Error

You will not be deprived of coverage under the Plan because of a clerical error. However, you will not be eligible for coverage beyond the scheduled termination of your coverage because of a failure to record the termination.

1. Introduction to Your Dental Coverage

J. How to Use the Plan

This Summary describes your covered services and how to obtain them. Depending on the dental plan option, Members will have In-Network Dental Benefits Only or In- and Out-of-Network Dental Benefits. The provisions below contain certain information you need to know to obtain covered services.

In-Network Providers. These are any of the participating licensed dentists or other dental care providers or facilities who have entered into an agreement with Delta Dental to provide dental care services to Members. Enrolling in the plan does not guarantee the availability of a particular provider on the list of network providers; provider availability depends on many factors, including but not limited to scheduling. When a provider is no longer part of the network, you must choose among remaining network providers to receive in-network benefits.

Out-of-Network Providers. These are licensed dentists or other dental care providers or facilities not participating as network providers. Services from out-of-network providers will be covered at the out-of-network benefit level in the Delta Dental Premier plan. Members in the Delta Dental PPO plan will be responsible for the full cost of services when using an out-of-network provider.

Note: All Members seeking services from out-of-network providers may be subject to balance billing from the provider. Balance billing means you are responsible for the difference between the treating dentist's submitted charges and the Allowed Amount, in addition to the out-of-network deductible/coinsurance.

2. Coverage Eligibility and Enrollment

A. Eligibility

The University of Minnesota develops eligibility criteria for its employees and their dependents subject to collective bargaining agreements and compensation plans that may change during a Plan Year. Employees are eligible to participate in the University of Minnesota Dental Program (the Plan) if all three criteria are met:

1) The appointment is in an eligible classification;

2) The appointment is 50% time or greater;

3) The appointment will last for three months or longer.

The University contributes a significant portion of the cost of dental benefits for an employee with an appointment of 75% time or greater. If the employee's appointment is 50% to 74% time, the employee is eligible to participate in the Plan but must pay full cost of coverage; there is no University contribution at this level of employment.

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

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

1. Definition of Eligible Dependents

The individuals listed on the chart on the following page are considered eligible dependents for the Plan. In addition to specifying criteria for coverage, the chart also includes information as to whether the dependent is considered qualified for favorable tax treatment under the Plan. See pages 13-15 for Tax Favored and Non-Tax Favored Treatment of Dependent Coverage for further explanation.

2. Residents/Fellows

Residents/fellows in job codes 9541, 9548, 9549, 9552, 9553, 9554, 9555, 9556, 9559, 9568, 9582, 9583, and 9569 are not covered in this Plan, but are covered in the University of Minnesota Residents/Fellows plan that is available at the following link: https://shb.umn.edu/health-plans/rfi.

2. Coverage Eligibility and Enrollment

Definition of Eligible Dependents and Qualification for Tax-Favored Treatment

The chart specifies the criteria for coverage along with whether the dependent is considered qualified for favorable tax treatment under the Plan. Go to the Benefits website at humanresources.umn.edu/benefits/benefits-eligibility for more information about eligibility for your dependents.

Relationship to Employee	Criteria for Coverage	Is Dependent Qualified for Tax-Favored Treatment[1]
Spouse	**Must be legally married**	Qualified
Dependent Child	**Dependent child — birth through age 25 (up to the 26th birthday)** An eligible child can include your unmarried or married biological child, legally adopted child or child placed for the purposes of adoption, foster child, stepchild, or any other child state or federal law requires be treated as a dependent. Note: The spouse of your eligible married dependent child is not eligible for coverage.	Qualified
	Disabled child — age 26 or above (no maximum) if physically or mentally disabled and either: • lives with you and does not provide over 50% of their own support, or • does not live with you but is at least 50% dependent on you	Qualified
Dependent Grandchild	**Grandchild as dependent child** — A grandchild is eligible for coverage as your child if placed in your legal custody or if the grandchild is legally adopted or placed with you for the purpose of adoption.	Qualified
	Additional grandchildren eligibility — An unmarried grandchild is also eligible under the Plan for coverage if 1) the grandchild is dependent upon you for principal support and maintenance but is a qualified tax dependent of another person, or 2) your unmarried grandchild is the dependent child of your unmarried dependent child, and even though the grandchild may be dependent upon you for principal support and maintenance, the grandchild would not be eligible to be your tax dependent under tax regulations. In these instances, the contributions made by the University to your grandchild's coverage as well as your contributions are considered taxable income on your tax returns. **Newborns** — Your newborn infant grandchild is eligible under the Plan for coverage if the grandchild is financially dependent upon you and resides with you continuously from birth. Coverage for the grandchild may terminate if the grandchild does not continue to reside with you continuously, if the grandchild does not remain financially dependent upon you, or when the grandchild reaches age 26.	Usually non-qualified

[1] "Tax-Favored Treatment" refers to how dependent coverage is treated for tax purposes.

2. Coverage Eligibility and Enrollment

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

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

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

b) If the column on the right above is marked "Non-qualified" for a given dependent category, it means that you will be taxed on the value of the University's contribution for your non-qualified dependent's coverage. This taxable value is called imputed income.

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

c) It is your responsibility as the employee to determine whether a dependent is considered to be a qualified or non-qualified dependent for purposes of determining whether coverage is tax-favored under the Plan, and to enroll your dependent in the correct manner. One general guideline is that if the child is considered your dependent for tax purposes, they are eligible for coverage on a tax-favored basis. Notice of any change in dependent tax status must be communicated to the University within 30 days of the change.

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

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

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

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

3. Eligible Dependent Children

a) An eligible child, unmarried or married, can include your own biological child, legally adopted child, or child placed for the purposes of adoption, foster child, stepchild, and any other child state or federal law requires be treated as a dependent.

i) For a child who is being adopted, the date of placement means the date you assume and retain the legal obligation for total or partial support of the child in anticipation of your adoption of the child. A child's adoption placement terminates upon the termination of the legal obligation of total or partial support.

ii) To be considered a dependent child, a foster child must be placed by the court in your custody.

iii) To be considered a dependent child, a stepchild must be the child of your spouse.

2. Coverage Eligibility and Enrollment

Note: The spouse of your eligible married dependent child is not eligible for coverage.

b) If both you and your spouse work for the University of Minnesota, then either of you, but not both, may cover your eligible dependent children/grandchildren. This also applies to two divorced or unmarried employees who share legal responsibility for their dependent children or grandchildren.

c) **Grandchild as dependent child** — A grandchild is eligible for coverage as your child if placed in your legal custody; or if the grandchild is legally adopted or placed with you for the purpose of adoption.

Additional grandchildren eligibility — An unmarried grandchild is also eligible under the Plan for coverage if 1) the grandchild is dependent upon you for principal support and maintenance, but is a qualified tax dependent of another person or 2) your unmarried grandchild is the dependent child of your unmarried dependent child, and even though the grandchild may be dependent upon you for principal support and maintenance, the grandchild would not be eligible to be your tax dependent under tax regulations. In these instances, the contributions made by the University to your grandchild's coverage as well as your contributions are considered taxable income on your tax returns.

Newborns — Your newborn infant grandchild is eligible under the Plan for coverage if the grandchild is financially dependent on you and resides with you continuously from birth. Coverage for the grandchild may terminate if the grandchild does not continue to reside with you continuously, if the grandchild does not remain financially dependent on you, or when the grandchild reaches age 26.

4. Eligibility of Spouse

If both you and your spouse work for the University of Minnesota, then either of you has the option of adding the other as a dependent to family coverage. The spouse added to the family coverage must waive employee coverage.

5. Coverage of Disabled Children of Any Age

a) Your dependent child of any age is eligible for coverage and tax-favored status if they are incapable of self-sustaining employment by reason of mental retardation, mental illness, mental disorder, or physical disability, and is chiefly dependent on you for their support and maintenance (meaning you provide for more than one-half of the child's support).

b) A dependent child must be certified by the Plan Medical Claims Administrator to be disabled prior to age 26, based on proof that the child meets the above requirements. In the absence of medical coverage and a Medical Claims Administrator review, the Dental Claims Administrator follows Michelle's Law (H.R.2851) in determining the disability of a dependent.

i) If for any reason you drop coverage for a disabled dependent prior to age 26, then wish to cover the child again, coverage must be added prior to the child turning age 26, and their disabled status recertified by the Claims Administrator.

ii) Once your disabled child has reached age 26, the child must be continuously covered under the Plan to maintain eligibility.

c) A disabled dependent child who is 26 years of age or older and unmarried at the time of your initial eligibility for coverage in the Plan may be enrolled for coverage if:

i) You (the employee) enroll for coverage during your initial eligibility period, and;

2. Coverage Eligibility and Enrollment

ii) The Plan Medical Claims Administrator certifies that the dependent meets the above requirements. Proof of disability status must be provided within 31 days of your initial date of eligibility and enrollment in the Plan.

The disabled dependent shall be eligible for coverage as long as they continue to be disabled and dependent, unless coverage otherwise terminates under the Plan.

A dependent child who is considered to be disabled by the Plan Medical Claims Administrator will be eligible for tax-favored coverage under the Plan, regardless of age.

6. Children Covered by Child Support Order

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

7. Not Eligible

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

8. Family Status Change

To make changes in your medical, dental, optional life coverage, or flexible spending accounts after you are first eligible or outside of the annual open enrollment period, you must have a change in family status. The coverage change must be consistent with the family status change. A request for change in your coverage due to a family status change must be made within 30 days of the date of change.

Failure to apply for a change in coverage within 30 days of the family status change means that you will not be able to make a change until the next available open enrollment period.

Family status changes include:

- Change in legal marital status, including marriage, divorce, or annulment.
- Death of your spouse or last eligible dependent child.
- Birth or adoption of your eligible dependent child.
- Change in last dependent child's eligibility because of age.
- Commencement or termination of employment for you, your spouse, or dependent.
- Changes in your or your spouse's employment status from part time to full time or from full time to part time.
- Change in the place of residence or worksite for you, spouse, or dependent to a location outside of the current plan's service area and the current plan is not available.

Call the OHR Contact Center if you have more specific questions about changes in your coverage.

9. Dependent Eligibility Verification

The University has a responsibility to ensure Plan resources are well managed and to apply the dependent eligibility rules fairly and equally. For these reasons, you will be asked to verify University benefits coverage eligibility of your dependents if they are added to your Plan coverage when you are a new employee, when you acquire a new dependent, or during open enrollment.

You will need to verify the eligibility of these dependents by providing documentation such as a tax form, marriage certificate, or a birth or adoption certificate.

Please respond to the verification request from Total Compensation promptly to ensure coverage for your dependents.

2. Coverage Eligibility and Enrollment

B. Effective Date of Coverage

1. The initial effective date of coverage is the first day of the month following the first day of employment, newly benefits-eligible position, reemployment, or reinstatement.

   You must be actively at work on the initial effective date of coverage, or coverage will be delayed until the date the employee returns to active payroll status.

   However, if you are not actively at work on the initial effective date of coverage due to your health status, medical condition, or disability, or that of your dependent, as such terms are defined in Section 9802(a) of the Internal Revenue Code and related regulations, coverage shall not be delayed.

2. If you and your dependents apply for coverage during an open enrollment period, coverage will become effective on January 1 of the following year.

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

4. Adopted children are covered from the date of placement for the purposes of adoption.

5. Disabled dependents are covered from your effective date of coverage.

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

C. Initial Enrollment

1. You must complete your enrollment for yourself and any eligible dependents within 30 days of date of hire or from the date you first become eligible, if currently employed. Payroll deductions will be based on your effective date of coverage, not on the date your enrollment was completed. Failure to enroll within 30 days will result in no coverage for you and any eligible dependents. However, you will be permitted to enroll at the next open enrollment or sooner in the event of a qualified change in family status (see **E. Midyear Enrollment Due to Status Change**).

2. You must complete your enrollment for a newly acquired eligible dependent within 30 days of when you first acquire the dependent (for example, through marriage). Payroll deductions will be based on the effective date of coverage, not on the date your enrollment was completed. Failure to enroll within 30 days will result in no coverage for the newly acquired dependent. The next opportunity to enroll the dependent will be at open enrollment or sooner in the event of a qualified change in family status (see **E. Midyear Enrollment Due to Status Change**).

D. Open Enrollment

During the University of Minnesota annual Open Enrollment period you may change dental plans, enroll in coverage for yourself, waive coverage, and add or drop dependents from your coverage for the upcoming plan year.

E. Midyear Enrollment Due to Status Change

If you have a status change and fail to enroll within the times listed below, you will lose that opportunity and cannot make a change until the next open enrollment period. Please take note of the time frames allowed for you to make midyear enrollment changes.

You may add coverage within your selected University dental plan option for all eligible dependents **within 30 calendar days** of the following events:

1. You legally marry.

2. If your dependent spouse loses group coverage, you may add family coverage. Loss of coverage includes any change in coverage that results in termination of your dependent's coverage, even if it is immediately replaced by other subsidized coverage.

   You must complete enrollment within 30 days of the date of loss of coverage in order to be eligible under this provision. You must also provide a statement from the former Dental Claims Administrator documenting the loss of coverage.

2. Coverage Eligibility and Enrollment

Loss of coverage does not include the following:

a) A change in Dental Claims Administrators through the same employer where the coverage is continuous and uninterrupted;

b) A change in your dependent's dental plan benefit levels; and

c) A voluntary termination of coverage by your dependent, including, but not limited to, termination or reduction of coverage due to the adoption of cafeteria-style plans.

3. When you acquire a dependent child. In addition, at this time you can add your spouse and any other eligible dependent children who have not been covered under the Plan.

4. When your dependent child to age 26 meets the eligibility criteria described in the chart in **A. Eligibility.**

F. Midyear Change to Dental Plan Selection

You and your dependents may be allowed to make a change to your dental plan selection outside of the initial period of eligibility or annual open enrollment. The midyear plan selection enrollment must occur within 30 calendar days of the status changes specified below.

1. Any Claims Administrator participating in the University of Minnesota Dental Plan is placed into reorganization or liquidation or is otherwise unable to provide the services specified in the Summary of Benefits.

2. Any Claims Administrator participating in the University of Minnesota Dental Plan loses all or a portion of its primary care provider network (including hospitals) to the extent that primary care services are not accessible or available within 30 miles of your work location or residence.

3. Any Claims Administrator participating in the University of Minnesota Dental Plan terminates or is terminated from participation in the Plan.

4. The University of Minnesota approves a request from an employee due to an administrative error that occurs during the open enrollment process.

5. An enrollee moves or is transferred to a location outside of the current plan's service area and the enrollee's current plan is not available.

6. Retirees may elect to change to another University dental plan in the **60 days** immediately preceding the effective date of retirement.

G. Adding New Dependents

Enrollment is required to add a new dependent. Filing a claim for benefits is not sufficient notice to add a dependent. This part outlines the time periods for enrollment and the date coverage starts. See **B. Effective Date of Coverage** for when coverage is effective.

1. Adding a spouse

A spouse is eligible on the date of legal marriage.

You must complete enrollment within 30 days after the legal marriage for coverage to become effective on the date of legal marriage.

2. Adding newborns

You have the option of enrolling the child within 30 days of the date of birth or waiting until open enrollment.

3. Adding children placed for adoption

Coverage will take effect on the date of placement. Enrollment for coverage should be completed within 30 days from the date of placement.

In all cases, application for coverage under the Plan must be made within 30 days of the event permitting enrollment and must include the following information: name, date of birth, gender, Social Security number, and relationship to the employee.

2. Coverage Eligibility and Enrollment

H. Affordable Care Act (ACA) Special Enrollment

If you are ineligible to participate in University Dental coverage because you initially work fewer than 30 hours per week or your weekly hours of service vary, you may become eligible to participate in University Dental coverage for one year, under guidelines of the ACA, if you have worked 30 hours or more per week on average during the past year. Eligibility for this coverage is determined once a year (using the same standard measurement period) for all employees who have worked over a year. Eligibility for new employees who have not yet completed one year of service is determined using an initial measurement period that is specific to each new employee. Each employee will be notified in writing if they become eligible under ACA guidelines. The employee will need to continue to work 30 hours or more per week on average in future years to remain eligible for ACA coverage for the following year.

I. Waive Coverage

You have the option as a new employee and during open enrollment to waive coverage, which means you do not have coverage, or to decrease dental coverage.

The following status change events also allow you to waive or decrease dental coverage midyear:

- Your legal marriage terminates
- You gain dental coverage through your spouse
- You experience a significant change in employer contributions
- You move to a new location outside of your current plan's service area and your current plan is not available
- You retire
- Your work appointment decreases to fewer than 30 hours per week.

If you decide to waive coverage as a result of a status change event, you must waive coverage **within 30 days** of the qualifying event. Failure to waive coverage within 30 days of the event will result in not being able to make changes until the following open enrollment.

J. Elect Coverage after Waiving Coverage

If you waived dental coverage, you can elect dental coverage again during the next open enrollment period, or midyear as a result of the following status change events:

- Your legal marriage
- The birth or adoption of your child
- The death of your spouse or last dependent child
- Your divorce
- You lose coverage through your spouse
- You experience a significant change in employer contributions
- Your dependent child to age 26 meets eligibility criteria as stated in the chart in **A. Eligibility**

If you decide to elect coverage as a result of a status change event, you must enroll **within 30 days** of the qualifying event. Failure to enroll within 30 days of the event will result in not being able to make changes until the following open enrollment.

K. Termination of Coverage

Coverage for you and/or your dependents will terminate on the earliest of the following dates, except that coverage may be continued in some instances as specified in **M. Continuation.**

1. For you and your dependents, the date that either the Claims Administrator or the University of Minnesota terminates the Plan.

2. For you and your dependents, the last day of the month in which you retire, unless you and your dependents are eligible for and elect to maintain coverage under this Plan or a separate Medicare contract.

3. For you and your dependents, the last day of the month in which you terminate employment or in which your eligibility under this Plan ends.

2. Coverage Eligibility and Enrollment

4. For you and your dependents, the last day of the month following the receipt of a written request by you to cancel coverage. Approval to terminate coverage will only be granted if the request is consistent with a status change. Status changes include, but are not limited to:

   a) loss of dependent status of a sole dependent;

   b) death of a sole dependent;

   c) divorce;

   d) change in employment condition of an employee or spouse;

   e) a significant change of spouse insurance coverage (cost of coverage is not a significant change); and

   f) during an open enrollment.

   In the event that you experience one of these status changes, you are obligated to contact the OHR Contact Center within 30 days.

5. For a child covered as a dependent, the last day of the month in which the child is no longer eligible as a dependent. Coverage terminates on the last day of the month in which a dependent turns age 26.

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

7. For an enrollee who is directly billed by the University of Minnesota, the last day of the month for which the last full payment was received, if the enrollee fails to make full payment within 30 days of the date the bill was due, whichever is later.

8. For any enrollee who is directly billed by the Claims Administrator and/or COBRA Administrator, the last day of the month for which the last payment was received, if the enrollee fails to make full payment within 30 days of the date the bill was due. Enrollees include COBRA participants, disabled participants, and retirees under age 65.

9. For a retiree and/or dependent over age 65 who terminates Medicare Part B Coverage, or who fails to apply for Medicare Part B Coverage within 30 days of the effective date of retirement, within 30 days after the retiree or dependent receives notice from the Claims Administrator.

   In the event you no longer meet eligibility requirements, but your coverage has inadvertently been continued, the date of coverage termination depends on whether the employee contribution payments have been made.

   a) If no or inadequate employee contribution payments have been made (including failure to make full continuation contribution payments for ineligible dependents), the coverage will be retroactively terminated to the date of loss or lack of eligibility.

   b) If full employee contribution payments have been made (including full continuation contribution payments), the University of Minnesota Dental Plan may terminate coverage prospectively.

2. Coverage Eligibility and Enrollment

L. Misuse of Plan

You will be subject to disciplinary action up to and including loss of coverage and termination of employment if you:

a) submit fraudulent, altered, or duplicate billings for any reason, including but not limited to submissions for personal gain;

b) enroll or allow another party who is not eligible or covered under this Plan to use your coverage or plan identification to obtain coverage;

c) fail to notify Total Compensation on a timely basis of loss of eligibility for your dependents; or

d) provide false, incorrect, or fraudulent information on your enrollment, including your enrollment of dependents, as well as on the Dependent Eligibility Verification request from the University.

M. Continuation

You or your covered dependents may continue coverage under this Plan if current coverage ends because of any of the qualifying events listed on the following page. You or your dependent must be covered under the Plan before the qualifying event in order to continue coverage. In all cases, continuation ends if the Plan ends or required charges are not paid when due.

The following section generally describes continuation coverage under this Plan. Also refer to **11. COBRA Notice** for more information.

2. Coverage Eligibility and Enrollment

Qualifying Event	Who May Continue	Maximum Continuation Period
Employment ends, certain leaves of absence, layoff, or reduction in hours (except gross misconduct dismissal)	Employees and dependents	Earlier of: • Enrollment date in other group coverage, or • 18 months
Divorce	Former spouse and any dependent children who lose coverage	Earlier of: • 36 months from the date of divorce • Enrollment in other group coverage, or • Date coverage would otherwise end
Death of employee	Surviving spouse and dependent children	Earlier of: • Enrollment date in other group coverage, or • Date coverage would otherwise end
Dependent child loses eligibility	Dependent child	Earlier of: • 36 months from the date of losing eligibility • Enrollment in other group coverage, or • Date coverage would otherwise end
Employee retires at age 65 or over and enrolls in Medicare Part A, Part B, or both	Employee and dependents	Earliest of: • 36 months from date of enrollment in Medicare • Enrollment in other group coverage, or • Date coverage would otherwise end
Surviving dependent of retiree on lifetime continuation due to bankruptcy of Employer	Surviving spouse and dependents	• 36 months following retiree's death
Total disability[1]	Employee and dependents	Earlier of: • Date total disability ends, or • Date coverage would otherwise end
Total disability of dependent[2]	Dependent	Earliest of: • 18 months, or • 29 months after the employee leaves employment, or • Date total disability ends, or • Date of enrollment in Medicare, or • Date coverage would otherwise end

2. Coverage Eligibility and Enrollment

[1]Total disability means the employee's inability to engage in or perform the duties of the employee's regular occupation or employment within the first two (2) years of the disability. After the first two (2) years, it means the employee's inability to engage in any paid employment or work for which the employee may, by education and training, including rehabilitative training, be or reasonably become qualified. For employees disabled prior to January 1, 1992, total disability means the employee's inability to engage in or perform the duties of the employee's regular occupation or employment from the date of disability.

[2]If the dependent is disabled at the time the employee leaves employment or becomes disabled within the first 60 days of continuation of coverage, continuation for the dependent may be extended beyond the 18 months of continuation. To qualify, the disabled dependent must meet the following notice requirements during the 18 months of continuation:

- The dependent must apply for Social Security benefits and be determined to have been totally disabled at the time of the qualifying event or within the first 60 days of continuation of coverage.

- The dependent must notify the COBRA administrator of the disability determination within 60 days after the disability determination.

1. Choosing continuation

   If you lose coverage, the Plan will notify you within 14 days after employment ends of the option to continue coverage. If coverage for your dependent ends because of divorce or any other change in dependent status, you or your covered dependents must notify Total Compensation in writing within 30 days after the qualifying event occurs.

   You or your covered dependents must choose to continue coverage by notifying the Plan by completing an application. You or your covered dependents have 60 days to choose to continue, starting with the date of the notice of continuation or the date coverage ended, whichever is later. Failure to choose continuation within the required time period will make you or your covered dependents ineligible to choose continuation at a later date.

   You or your covered dependents have 45 days from the date of choosing continuation to pay the first continuation charges. After this initial grace period, you or your covered dependents must pay charges monthly in advance to the COBRA administrator to maintain coverage in force.

   Charges for continuation are the University group rate plus a two-percent (2%) administration fee. (If the qualifying event for continuation is the employee's total disability, the administration fee is not required.) All charges are paid according to the instructions in the COBRA and State Continuation Coverage form.

2. Additional qualifying events

   If additional qualifying events occur during continuation, dependent qualified beneficiaries may be entitled to election rights of their own and an extended continuation period. This only applies when the initial qualifying event for continuation is the employee's termination of employment, reduction in hours, retirement, leave of absence, or layoff.

   When a second qualifying event occurs, such as the death of the former covered employee, the dependent must notify the employer of the additional event within 31 days after it occurs to continue coverage. Continuation charges must be paid in the same manner as for the initial qualifying event.

   A qualified beneficiary is any individual covered under the Dental Plan the day before the qualifying event, as well as a child who is born or placed for adoption with the covered employee during the period of continuation of coverage.

3. Cost verification

The University will provide you or your eligible dependents, on request, written verification of the cost of continuation coverage at the time of eligibility or at any time during the continuation period.

N. Choosing a Dental Plan

Eligible employees and their dependents may select a dental plan based on either work location or where they live. There may be other options that you can choose, but they have limited provider availability. All other enrollees (disabled, COBRA, and early retirees) may choose a dental plan based on where they live.

O. Retirement

An employee covered by the Plan who is retiring from the University at age 55 or older with five years of service, age 50 to 54 with 15 years of service, or regardless of age with 30 years of service, who is eligible to maintain participation in the Plan may maintain dental coverage with the University. Individuals on a University separation program, meeting the above criteria, are eligible to continue in the Plan regardless of age.

The employee must complete the proper forms with the University preferably before retirement but within 30 days after the effective date of retirement.

If the employee did not choose coverage for dependents upon retirement, the employee may add them later if an eligible spouse loses other group coverage or if the employee marries after retirement. The employee must send a written request for a change in coverage to Total Compensation within 30 days of the event.

If a retiring employee fails to make a proper election within the 30-day time period, the retiring employee may continue coverage for up to 18 months in accordance with state and federal law.

See item **M. Continuation** for information on your continuation rights.

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

P. Long-Term Disability

An employee covered by the University Dental Program who is approved under a University-sponsored Long-Term Disability program may maintain dental coverage with the University by paying the full cost. When disability status ceases, the individual may continue dental coverage for the remainder of the COBRA entitlement period, which runs concurrently with the benefits extended under this program in accordance with state and federal law.

See item **M. Continuation** for information on your continuation rights.

However, the employee may maintain dental coverage indefinitely with the University under the University Dental Program provided that the retirement age and service requirements are met. In any event, failure to pay the premium will result in termination of coverage.

3. Plan Descriptions

A. Delta Dental PPO

Delta Dental PPO is an affordable, network-only plan. This plan offers benefits and the greatest cost savings when recieving care from a dentist participating in the Delta Dental PPO network. Delta Dental PPO does not offer our-of-network coverage except for emergency situations. The Delta Dental PPO network includes 1,900 participating dentists and specialists in 77 Minnesota counties and border communities. Additionally, the national Delta Dental PPO network offers 113,500 participating dentists across the country.

A Delta Dental PPO network dentist is a dentist who has signed a Delta Dental PPO agreement with Delta Dental of Minnesota. The dentist has agreed to accept the Delta Dental PPO Maximum Amount Payable as payment in full for covered dental care. You will be responsible for any applicable deductible and coinsurance amounts listed in the **4. Benefit Features** section. A Delta Dental PPO dentist has agreed not to bill more than the Delta Dental PPO Maximum Amount Payable. A Delta Dental PPO dentist has also agreed to file the claim directly with Delta Dental.

You do not need to select a primary dental clinic when you enroll.

B. Delta Dental Premier

Delta Dental Premier is a flexible plan that offers access to the broad Delta Dental Premier network, as well as access to the more cost-effective Delta Dental PPO network. Delta Dental Premier is the largest dental network in the country, with over 155,500 participating providers. In Minnesota, the Delta Dental Premier network is also the largest dental network, with more than 2,900 participating dentists and specialists in 85 Minnesota counties and border communities. Seeing a dentist in either of the Delta Dental networks will help you make the most of your benefits and can result in lower out-of-pocket costs. While you can always visit an out-of-network dentist, your out-of-pocket costs may be higher.

A Delta Dental Premier dentist is a dentist who has signed a participating and membership agreement with their local Delta Dental Plan. The dentist has agreed to accept Delta Dental's Maximum Amount Payable as payment in full for covered dental care. Delta Dental's Maximum Amount Payable is a schedule of fixed dollar maximums established solely by Delta Dental for dental services provided by a licensed, participating dentist. You will be responsible for any applicable deductible and coinsurance amounts listed in the **4. Benefit Features** section. A Delta Dental Premier dentist has agreed not to bill more than Delta Dental's allowable charge. A Delta Dental Premier dentist has also agreed to file the claim directly with Delta Dental.

You do not need to select a primary dental clinic when you enroll.

How to Access a Provider Directory

You can find the most up-to-date information on participating providers on Delta Dental's website at www.deltadentalmn.org/uofm. If you need additional information, call Delta Dental Customer Service Center at 651-406-5916 or 1-800-553-9536.

Note: When you call to make a dental appointment, always verify that the dentist is in-network for your dental plan.

C. OUT-OF-NETWORK PROVIDERS (Delta Premier only): Reimbursement is based on 50% of the Allowed Amount.

If you use an out-of-network provider, you will receive significantly lower reimbursement amounts for services compared to the reimbursements you would receive from a Delta Dental in-network provider. It is strongly encouraged that your provider submit a pre-treatment estimate prior to services being received. This will prevent any surprise charges after treatment has been received. If you receive services from an out-of-network provider, you may need to:

- Pay for services up-front
- Pay more money for services than you would with an in-network dentist
- File the dental claim form with Delta Dental
- Receive reimbursements sent directly to you from Delta Dental

4. Benefit Features

A. Benefits

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

As a condition precedent to the approval of claim payments, the Claims Administrator shall be entitled to request and receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which a dentist's care is provided, such information and records relating to a Member as may be required to pay claims. Also, the Claims Administrator may require that a Member be examined by a dental consultant retained by the Claims Administrator in or near the Member's place of residence. The Claims Administrator shall hold such information and records confidential.

To avoid any misunderstanding of benefit payment amounts, ask your Dentist about his or her network participation status within your Plan network prior to receiving dental care.

The Claims Administrator does not determine whether a service submitted for payment or benefit under this Plan is a dental procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. The Claims Administrator evaluates dental procedures submitted to determine if the procedure is a covered benefit under your dental Plan.

Your dental Plan includes a preset schedule of dental services that are eligible for benefit by the Claims Administrator.

Other dental services may be recommended or prescribed by your dentist that are dentally necessary, offer you an enhanced cosmetic appearance, or are more frequent than covered by the Plan. While these services may be prescribed by your dentist and are dentally necessary for you, they may not be a dental service that is covered by this Plan or they may be a service where the Plan provides a payment allowance for a service that is considered to be optional treatment.

If the Plan gives you a payment allowance for optional treatment that is covered by the Claims Administrator, you may apply this Plan payment to the service prescribed by your dentist that you elected to receive. Services that are not covered by the Plan or exceed the frequency of Plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for dental services that are not covered by the Claims Administrator. Determination of services necessary to meet your individual dental needs is between you and your dentist.

ONLY those services listed are covered. Deductibles and maximums are listed under the Plan Comparison Chart. Covered services are subject to the limitations described within 4. Benefit Features and 5. Exclusions and General Limitations.

B. Pre-Treatment Estimate (Estimate of Benefits)

It is recommended that your dentist submit a claim form outlining the proposed treatment to the Dental Claims Administrator prior to treatment to estimate the amount of payment if your dental treatment involves major restorative, periodontic, prosthetic, or orthodontic care. The pre-treatment estimate is a valuable tool for both you and the dentist.

Submission of a pre-treatment estimate allows the dentist and the Member to know what benefits are available to the Member before beginning treatment. The pre-treatment estimate will outline the Member's responsibility to the dentist with regard to deductibles, coinsurance, and non-covered services and allow the dentist and the Member to make any necessary financial arrangements before treatment begins.

This process does not authorize the treatment nor determine its dental or medical necessity. The estimated Delta Dental payment is based on the Member's current eligibility and available contract benefits.

The subsequent submission of other claims, a change in eligibility, a change in the contract coverage, or the existence of other coverage may alter the Delta Dental final payment amount as shown on the pre-treatment estimate form.

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

C. Claim Payments

Delta Dental bases claim payments on the Plan's Payment Obligation, which is defined separately for each Plan.

For **Delta Dental PPO** dentists, claim payments are based on the Plan's Payment Obligation, which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental PPO dentist to a Delta Dental Member.

The Plan Payment Obligation for Delta Dental PPO dentists is the lesser of:

1) The fee pre-filed by the dentist with their Delta Dental organization;
2) The Delta Dental PPO Maximum Amount Payable as determined by Delta Dental;
3) The fee charged or accepted as payment in full by the Delta Dental PPO dentist regardless of the amount charged.

All Plan Payment Obligations are determined prior to the calculation of any Member deductibles and coinsurance as provided under the Member's Delta Dental program.

For **Delta Dental Premier** dentists, claim payments are based on the Plan's Payment Obligation, which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental Premier dentist to a Delta Dental Member.

The Plan Payment Obligation for Delta Dental Premier dentists is the lesser of:

1) The fee pre-filed by the dentist with their Delta Dental organization;
2) The Maximum Amount Payable as determined by Delta Dental;
3) The fee charged or accepted as payment in full by the Delta Dental Premier dentist regardless of the amount charged.

All Plan Payment Obligations are determined prior to the calculation of any Member deductibles and coinsurance as provided under the Member's Delta Dental program.

For **Nonparticipating** Providers, claim payments are based on the Plan's Payment Obligation, which is the treating dentist's submitted charge or the Table of Allowances, whichever is less. The Table of Allowances is a schedule of fixed dollar maximums established solely by Delta Dental for services rendered by a licensed dentist who is a Nonparticipating Provider. Claim payments are sent directly to the Member.

4. Benefit Features

Out-of-Network Providers

Note: All Members seeking services from out-of-network providers may be subject to balance billing from the provider. Balance billing means you are responsible for the difference between the treating dentist's submitted charges and the Allowed Amount, in addition to the out-of-network deductible/ coinsurance.

D. Plan Maximums

The annual Plan maximum for all benefits per person per contract year is $2,000.

However, the orthodontic benefit has a separate $2,800 lifetime maximum per covered dependent up to age 19. The orthodontic benefit does not start over if you change plans.

E. Emergency Services

Benefit	Delta Dental PPO	Delta Dental Premier	
Emergency Services	**In-Network Only**	**In-Network**	**Out-of-Network**
1. Emergency Dental Services	In-network services provided same as any service; out-of-network services apply $50 deductible then same as any in-network services	Provided same as eligible dental services	

This applies only to Delta Dental PPO

You will be reimbursed for out-of-network emergency dental services at the in-network coinsurance level, after a $50 deductible. You will be responsible for the deductible and your coinsurance for the emergency dental services provided by a nonparticipating dentist.

Covered Services

Emergency dental treatment, including diagnostic and palliative procedures for:

- A dental emergency that involves acute pain; and
- A dental condition that requires immediate treatment.

Not Covered

- Services that Delta Dental determines are not emergency in nature.

4. Benefit Features

F. Preventive Care

Benefit	Delta Dental PPO	Delta Dental Premier	
Preventive Care	**In-Network Only**	**In-Network**	**Out-of-Network**
1. Diagnostic and Preventive Services	100%	100%	50%

Covered Services

- **Oral and Comprehensive Evaluations** — Covered one time per dental office, subject to the two times per calendar year limitation. Any additional comprehensive oral evaluations performed by the same dental office will be covered as a periodic oral evaluation and will be subject to the two times per calendar year limitation.
- **Limited Oral Evaluations** — Covered one time per calendar year and are separate from all other oral exams.
- **Radiographic Images (X-rays)**
  - Bitewings — Covered at one series of bitewings per calendar year.
  - Full Mouth (Complete Series) or Panoramic — Covered one time per three-year period.
  - Periapical(s) — single X-rays.
  - Occlusal — Covered at two series per 24-month period.
- **Dental Cleaning**
  - Prophylaxis — A procedure to remove plaque, tartar (calculus), and stain from teeth. A prophylaxis performed on a Member under the age of 14 will be covered as a child prophylaxis. A prophylaxis performed on a Member age 14 or older will be covered as an adult prophylaxis.
  - Periodontal Maintenance (Prophylaxis) — A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation, and gum pocket measurements for patients who have completed periodontal treatment.
    - Two dental prophylaxes per calendar year;
    - An additional two periodontal maintenance (prophylaxis) per calendar year; or
    - A total of four periodontal maintenance (prophylaxis) per calendar year.
- **Fluoride Treatment** (Topical application of fluoride) — Covered one time per 12-month period for dependent children through the age of 18. Additional fluoride treatments are available through a Member's primary care medical provider.
- **Space Maintainers** — Covered one time per lifetime on eligible dependent children through the age of 16 for extracted primary posterior (back) teeth.

Not Covered

- Fluoride Treatment is not covered for adults and/or dependents who are age 19 or over.
- Oral Hygiene Instructions. It should be inclusive in an evaluation appointment.
- Please refer to **5. Exclusions and General Limitations.**
- Cone beam CT imaging and interpretation.

4. Benefit Features

G. Basic Restorative Care

Benefit	Delta Dental PPO	Delta Dental Premier	
Basic Restorative Care	**In-Network Only**	**In-Network**	**Out-of-Network**
1. Fillings, Sealants, and Other Services	80%	80%	After $125 deductible, 50%

Covered Services

- **Emergency Treatment** — Emergency (palliative) treatment for the temporary relief of pain or infection.
- **Amalgam (silver) Restorations** — Treatment to restore decayed or fractured permanent or primary teeth. Coverage will be limited to only one service per tooth surface per 24-month period.
- **Composite (white) Resin Restorations** — Coverage will be limited to only one service per tooth surface per 24-month period.
  - **Anterior (front) Teeth** — Treatment to restore decayed or fractured permanent or primary anterior teeth.
  - **Posterior (back) Teeth** — Treatment to restore decayed or fractured permanent or primary posterior teeth.
- **Sealants or Preventive Resin Restorations** — Any combination of these procedures is covered one time per lifetime for permanent first and second molars of eligible dependent children through the age of 18.
- **Intravenous Conscious Sedation and IV Sedation** — Covered when performed in conjunction with covered oral surgery services.
- **General Anesthesia or Analgesia** — Covered when performed in conjunction with covered oral surgery services.
- **Amalgam or Composite (white) Resin Restorations**
  - Back teeth
    - » Delta Dental PPO: Amalgam (silver) fillings
    - » Delta Dental Premier: Composite (white) fillings
  - Front teeth
    - » Both plans: Composite (white) fillings
- » **General Anesthesia, Analgesia, or Nitrous Oxide**
  - When performed in conjunction with covered oral surgery services.

Not Covered

- Case presentation and office visits.
- Athletic mouthguard, enamel microabrasion, and odontoplasty.
- Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes, but is not limited to tooth-whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base, or liner used under a restoration.
- Please refer to **5. Exclusions and General Limitations.**
- Amalgam or composite restorations placed for preventive or cosmetic purposes.
- Oral hygiene instructions.

4. Benefit Features

G. Basic Restorative Care

Benefit	Delta Dental PPO	Delta Dental Premier	
Basic Restorative Care	**In-Network Only**	**In-Network**	**Out-of-Network**
2. Other Restorative Services, including Inlays, Onlays, and Crowns	80%	80%	After $125 deductible, 50%

Covered Services

- **Gold Foil Restorations** — Coverage shall equal an amalgam (silver) restoration for the same number of surfaces. The Member must pay the difference in cost between the plan's payment obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.
- **Inlays** — Coverage shall equal an amalgam (silver) restoration for the same number of surfaces.
- **Note:** If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the Member must pay the difference in cost between the Plan's payment obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.
- **Onlays or Permanent Crowns** — Covered one time per five-year period per tooth.
- **Implant Crowns** — All covered implant-related services will be covered under the Prosthetics Services benefit. See Prosthetic Services in **H. Major Restorative Care.**
- **Crown Repair** — Covered one time per 12-month period per tooth.
    - Limitation on the replacement of an existing crown: Benefit for the replacement of a crown or inlay/onlay will be provided only after a five-year period measured from the date on which the procedure was last covered.
- **Pre-Fabricated or Stainless Steel Crown** — Covered one time per 24-month period for eligible dependent children through the age of 18.
- **Restorative Cast Post and Core Build-up, including one post per tooth and one pin per surface** — Covered one time per five-year period when done in conjunction with covered complex or major restorative services.
- **Canal prep & fitting of preformed dowel & post**
- **Occlusal procedures (including occlusal guard and adjustments)** — Covered through the age of 18.

Not Covered

- Procedures designed to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting, and gnathologic recordings.
- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes, but is not limited to, tooth-whitening agents or tooth bonding and veneer covering of the teeth.
- Please refer to **5. Exclusions and General Limitations.**
- Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
- Temporary, provisional, or interim crown.

4. Benefit Features

G. Basic Restorative Care

Benefit	Delta Dental PPO	Delta Dental Premier	
Basic Restorative Care	**In-Network Only**	**In-Network**	**Out-of-Network**
3. Endodontic Services — Nerve or Pulp Treatment	80%	80%	After $125 deductible, 50%

Covered Services

- **Endodontic Therapy on Primary Teeth**
  - Pulpal Therapy
  - Therapeutic Pulpotomy
- **Endodontic Therapy on Permanent Teeth**
  - Root Canal Therapy
  - Apicoectomy
  - Root Amputation on posterior (back) teeth
- **Complex or other Endodontic Services**
  - Apexification — For dependent children through the age of 16
  - Retrograde filling
  - Hemisection, includes root removal

Plan Differences

- **Retreatment of Endodontic services that have been previously covered under the Plan** — Covered one time per two years.

Not Covered

- Bleaching of discolored teeth.
- Pulpal regeneration.
- Please refer to **5. Exclusions and General Limitations.**
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment.
- Intentional reimplantation.

4. Benefit Features

G. Basic Restorative Care

Benefit	Delta Dental PPO	Delta Dental Premier	
Basic Restorative Care	**In-Network Only**	**In-Network**	**Out-of-Network**
4. Periodontics — Gum & Bone Treatment	80%	80%	After $125 deductible, 50%

Covered Services

- **Basic Non-Surgical Periodontal Care** — Treatment for diseases for the gingival (gums) and bone supporting the teeth.
  - Root Planing and Scaling — Covered once per quadrant in 24 consecutive months.
  - Full mouth debridement — Covered one time per lifetime.
- **Complex Surgical Periodontal Care** — Covered one time per three-year period per single tooth or multiple teeth in the same quadrant.
- **Surgical treatment for diseases for the gingival (gums) and bone supporting the teeth.** The following services are considered Complex Surgical Periodontal Care under this Plan.
  - Gingivectomy/gingivoplasty
  - Gingival flap
  - Apically positioned flap
  - Osseous surgery
  - Bone replacement graft
  - Pedicle soft tissue graft
  - Free soft tissue graft
  - Subepithelial connective tissue graft
  - Soft tissue allograft
  - Combined connective tissue
  - Distal/proximal wedge

Not Covered

- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- Medicines or drugs for non-surgical or surgical dental care, regardless of the method of administration.
- **Note:** Antibiotics administered by the dental provider in the dental office will be covered.
- Please refer to **5. Exclusions and General Limitations.**
- The controlled release of therapeutic agents or biologic materials used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization of teeth.

4. Benefit Features

G. Basic Restorative Care

Benefit	Delta Dental PPO	Delta Dental Premier	
Basic Restorative Care	**In-Network Only**	**In-Network**	**Out-of-Network**
5. Oral Surgery — Tooth, Tissue, or Bone Removal	80%	80%	After $125 deductible, 50%

Covered Services

- **Basic Extractions**
  - Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
  - Extraction of erupted tooth or exposed root
- **Complex Surgical Extractions**
  - Surgical removal of erupted tooth
  - Surgical removal of impacted tooth
  - Surgical removal of residual tooth roots
- **Other Complex Surgical Procedures**
  - Surgical exposure of impacted or unerupted tooth to aid eruption
  - Transseptal fiberotomy
  - Alveoloplasty
  - Vestibuloplasty
  - Removal of nonodontogenic or odontogenic cyst or tumor
  - Removal of exostosis
  - Partial ostectomy
  - Frenulectomy
  - Harvest of bone for use in autogenous grafting procedures
- **Temporomandibular Joint Disorder (TMJ) as covered under Minnesota Statutes Section 62A.043 Subd. 3**

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

  Note: If you or your dependents currently have medical insurance coverage, the claim must first be submitted to that medical insurance program. Any remaining costs after consideration under your medical insurance may be submitted to the Plan for further benefit (see **7. Coordination of Benefits**). You must submit a copy of the medical Explanation of Benefits (EOB) along with your claim to your Dental Plan.

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

4. Benefit Features

- **Limitations**

  1. Reconstructive Surgery benefits shall be provided for reconstructive surgery when such dental procedures are incidental to or follow surgery resulting from injury, illness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, to the extent as required by Minnesota Statute 62A.25, provided, however, that such procedures are dental reconstructive surgical procedures.

  2. Inpatient or outpatient dental expenses arising from dental treatment up to age 18, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate as required by Minnesota Statute section 62A.042.

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

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

- **Other Complex Surgical Procedures** — Oroantral fistula closure, Tooth reimplantation (accidentally evulsed or displaced tooth), Biopsy of oral tissue, Excision of lesion or tumor, and Incision and drainage of abscess.

  Note: These services may be covered under your Medical Plan. Please contact your Dental Plan directly for dental plan consideration.

Not Covered

- Medicines or drugs for non-surgical or surgical dental care, regardless of the method of administration.

  Note: Antibiotics administered by the dental provider in the dental office will be covered.

- Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
- Surgical repositioning of teeth.
- Inpatient or outpatient hospital expenses.
- Cytology sample collection – Collection of oral cytology sample via scraping of the oral mucosa.
- Please refer to **5. Exclusions and General Limitations.**
- Non-Intravenous conscious sedation.
- Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
- Surgical exposure of impacted or unerupted tooth for orthodontic reasons — Coverage is excluded for these services under the Oral Surgery benefit. See **I. Orthodontics** for coverage details.

4. Benefit Features

H. Major Restorative Care

Benefit	Delta Dental PPO	Delta Dental Premier	
Major Restorative Care	**In-Network Only**	**In-Network**	**Out-of-Network**
1. Prosthetic Services — Dentures, Partials, Bridges, and Implants	50%	50%	No coverage

Covered Services

- **Removable Prosthetic Services (Dentures and Partials)** — Covered one time per five-year period:
  - For Members age 16 or older;
  - For the replacement of extracted (removed) permanent teeth;
  - If five years have elapsed since the last covered removable prosthetic appliance (denture or partial) and the existing appliance needs replacement because it cannot be repaired or adjusted.
- **Fixed Prosthetic Services (Bridge)** — Covered one time per five-year period:
  - For Members age 16 or older;
  - For the replacement of extracted (removed) permanent teeth;
  - If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last five years.
  - If five years have elapsed since the last covered removable prosthetic appliance (bridge) and the existing appliance needs replacement because it cannot be repaired or adjusted.
- **Implants (Single Tooth Implant Body, Abutment, and Crown)** — Covered one time per five-year period:
  - For Members age 16 or older;
  - Coverage includes only the single surgical placement of the implant body, implant abutment, and implant/abutment supported crown.

  Note: Some adjunctive implant services may not be covered. It is recommended that you send in a Pre-Treatment Estimate, so you know what is covered prior to beginning treatment.
- **Restorative cast post and core build-up, including pins and posts** — Covered one time per five-year period when done in conjunction with covered fixed prosthetic services.
- **Reline, Rebase, Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s)** — Covered when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and only after six months following initial placement of the prosthetic appliance (denture, partial, or bridge).
- **Adjustments** — Covered two times per 12-month period when the prosthetic appliance (denture, partial, or bridge) is the permanent prosthetic appliance; and only after six months following initial placement of the prosthetic appliance (denture, partial, or bridge).
- **Interim removable or interim fixed prosthetic appliances (interim abutment, dentures, partials or bridges)** — Interim partial denture — Covered — 1 time per 60 months to age 19.

4. Benefit Features

Not Covered

- Replacement of misplaced, lost, or stolen dental prosthetic appliances.
- Placement or removal of sedative filling, base, or liner used under a restoration.
- Pediatric removable or fixed prosthetic appliances (dentures, partials, or bridges).
- Procedures designed to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting, and gnathologic recordings.
- Services or supplies that have the primary purpose of improving the appearance of your teeth.
- Please refer to **5. Exclusions and General Limitations.**
- The replacement of an existing partial denture with a bridge.
- Additional, elective, or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
- Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.

4. Benefit Features

I. Orthodontics

Benefit	Delta Dental PPO	Delta Dental Premier	
Orthodontics	**In-Network Only**	**In-Network**	**Out-of-Network**
1. Treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies on covered eligible dependent children through the age of 18	80%	80%	50%
	Subject to separate **$2,800 lifetime maximum** per covered dependent, which does not start over if you change plans.		

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

Covered Services

- **Limited Treatment** – Treatments that are not full treatment cases and are usually done for minor tooth movement.
- **Interceptive Treatment** – A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- **Comprehensive (complete) Treatment** – Full treatment includes all records, appliances, and visits.
- **Removable Appliance Therapy** – An appliance that is removable and not cemented or bonded to the teeth.
- **Fixed Appliance Therapy** – A component that is cemented or bonded to the teeth.
- **Other Complex Surgical Procedures** – Surgical exposure of impacted or unerupted tooth for orthodontic reasons and surgical repositioning of teeth. Covered services under the orthodontic benefit.

Not Covered

- Monthly treatment visits that are inclusive of treatment cost.
- Repair or replacement of lost, broken, or stolen appliances.
- Orthodontic retention/retainer as a separate service.
- Retreatment or services for any treatment due to relapse.
- Inpatient or outpatient hospital expenses.
- Provisional splinting, temporary procedures, or interim stabilization of teeth.
- Please refer to **5. Exclusions and General Limitations.**

4. Benefit Features

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. The Member must have continuous eligibility under the Plan to receive ongoing orthodontic benefit payments.

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

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

When treatment begins, the dentist should submit the Estimate of Benefit form with the date of placement and their signature. After benefit and eligibility verification by the Plan, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be issued to you and your dentist. This again will serve as the claim form to be submitted six months from the date of appliance placement.

Payments are made in equal amounts:

1. When treatment begins (appliances are installed),
2. At the 12-month interval, and
3. At the 18-month interval or until the lifetime maximum benefits are exhausted.

5. Exclusions and General Limitations

The Plan excludes from benefits coverage and does not pay for:

1. **Treatment, procedures, or services that are not dentally necessary** or that are primarily educational in nature or for the vocation, comfort, convenience, appearance, or recreation of the Member.
2. The **treatment of conditions** which foreseeably result from excluded services.
3. **Treatment, procedures, or services that are not provided by a network dentist** or other authorized provider or are not authorized by the Claims Administrator. **Note:** This exclusion applies only to the Delta Dental PPO plan.
4. Dental services performed **other than by a licensed dental health professional.**
5. Dental services or supplies rendered **outside the service area,** except for emergency services. **Note:** This exclusion applies only to the Delta Dental PPO plan. (See **E. Emergency Services.**)
6. Dental services that are **performed primarily for cosmetic purposes** or for the purpose of improving the appearance of your teeth. This includes tooth whitening, tooth bonding, and veneers that cover the teeth. **Note:** Dental services are subject to post-payment review of dental records. If services are found to be cosmetic, the Claims Administrator reserves the right to collect any payment and the Member is responsible for the full charge.
7. **Amalgam or composite restorations** placed for preventive or cosmetic purposes.
8. **Placement of an infiltrating resin restoration** for strengthening, stabilizing, and/or limitation of the progression of the lesion.
9. Dental services **completed prior to the date** the Member became eligible for coverage.
10. **Hospitalization** or other facility charges.
11. **Local anesthesia** or use of electronic analgesia billed as a separate procedure is not covered. Nitrous oxide is not covered unless dentally necessary and required to perform a covered dental procedure. General anesthesia and intravenous sedation are not covered except as indicated in **4. Benefit Features.**
12. **Orthodontic services,** except as indicated in **4. Benefit Features.**
13. **Orthognathic surgery** (surgery to reposition the jaws). **Note:** These services may be covered under your Medical Plan.
14. **Services that are investigative,** elective, experimental, or not otherwise clinically accepted.
15. Procedures, appliances, or restorations that are **necessary to alter, restore, or maintain occlusion,** including but not limited to: increasing vertical dimension, replacing, or stabilizing tooth structure lost by attrition or erosion, or realigning teeth, except as covered orthodontic services indicated in **4. Benefit Features.**
16. **Mandibular orthopedic appliances** and bite planes.
17. Services for the following items:

    a. Replacement of any missing, lost, or stolen dental **prosthetics.**

    b. Replacement or repair of orthodontic **appliances.**

    c. Replacement of orthodontic appliances due to **non-compliance.**
18. Services related to a **prosthetic or special restorative appliance** that was installed or delivered more than 60 days after termination of coverage.
19. **Diagnostic testing** that is performed and billed as a separate procedure, such as collection of microorganisms for culture, viral cultures, genetic testing for susceptibility, or oral disease and caries susceptibility tests.
20. Dental services, supplies, and devices **not expressly covered** as a benefit indicated in **4. Benefit Features.**

5. Exclusions and General Limitations

21. **Prescription drugs and medications** prescribed by a dentist. **Note:** Antibiotics administered by the dental provider in the dental office will be covered.
22. Services provided to the Member that the **Member is not required to pay.**
23. The portion of a billed charge for an otherwise covered service by a non-network provider that is in excess of the **usual and customary charge.** Also not covered are charges or a portion of a charge that is either a duplicate charge for a service or charges for a duplicate service.
24. Services for **injury or illness** either a) arising out of an injury in the course of employment and subject to workers' compensation or similar law; or b) for which benefits are payable without regard to fault, under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance; or c) for which benefits are payable under another policy of accident and health insurance, Medicare, or any other governmental program.
25. Except where expressly addressed in **4. Benefit Features** when **multiple, acceptable treatment** options exist related to a specific dental problem, the Plan will provide benefits based on the least costly alternative treatment.
26. Services or supplies to treat any dental diseases, defect, or injury that is due to an **act of war,** declared or undeclared.
27. Services **covered under the Member's medical plan,** except to the extent not covered under the Member's medical plan.
28. **Additional charges for office visits** that occur after regularly scheduled hours, office visits for observation, missed appointments, or appointments canceled on short notice.
29. **Periodontal** splinting.
30. Athletic **mouthguards,** enamel microabrasion, and odontoplasty.
31. **Case presentations** and office visits.
32. **Consultations.**
33. **Retreatment** or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
34. **Bacteriologic** tests.
35. **Cytology** sample collection.
36. **Separate services** billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.
37. Pediatric removable or fixed **prosthetic appliances** (dentures, partials, or bridges).
38. Interim or temporary removable or **interim fixed prosthetic appliances** (interim abutment, dentures, partials, or bridges).
39. The replacement of an existing **partial denture** with a bridge.
40. Additional, elective, or enhanced **prosthodontic procedures** including, but not limited to, connector bar(s), stress breakers, and precision attachments.
41. Placement or removal of **sedative filling,** base, or liner used under a restoration.
42. Services or supplies that are **medical in nature,** including dental oral surgery services performed in a hospital.
43. **Fluoride Treatment** for adults and/or dependents who are age 19 or over.
44. Charges for **infection control,** sterilization, and waste disposal.
45. Charges for **sales tax.**
46. **Pulpal regeneration.**
47. **Cone beam CT imaging** and interpretation.

5. Exclusions and General Limitations

General Limitations

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

2. Reconstructive Surgery: Benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, to the extent as required by MN Statute 62A.25, provided, however, that such services are dental reconstructive surgical services.

3. Benefits for inpatient or outpatient expenses arising from dental services up to age 18, including orthodontic and oral surgery services, involved in the management of birth defects known as cleft lip and cleft palate as required by Minnesota Statutes Section 62A.042. For Programs without orthodontic coverage: Dental orthodontic services not related to the management of the congenital condition of cleft lip and cleft palate are not covered under this dental benefit program. For Programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this Plan shall be primary and the other policy or contract shall be secondary.

6. Definitions

Allowed Amount
A set amount the Plan agrees to pay for a service or product when provided by a participating In-Network provider. When the charges of an out-of-network provider are higher than the Allowed Amount, the Member is generally responsible for the difference.

Amalgam
A silver filling material.

Benefit Features Chart
A chart in **Section 4.** of this Summary of Benefits that lists specific benefit amounts for covered services.

Claims Administrator
Delta Dental is the entity that handles the day-to-day operations of the dental plan options. The Claims Administrator contracts with providers, provides customer service, adjudicates claims, and provides a variety of other services to Members on behalf of the Plan Sponsor (the University of Minnesota).

Clinically Accepted Dental Services
Techniques or services, accepted for general use, based on risk/benefit implications. Some clinically accepted techniques are approved only for limited use, under specific circumstances.

Coinsurance
The percentage of the Allowed Amount you must pay for certain covered services. Coinsurance applies after any applicable deductibles.

Composite
A white filling material. (Also see Customary Restorative Materials)

Consultations
Diagnostic services provided by a dentist or dental specialist other than the practitioner who is providing treatment.

Cosmetic Care
Dental services to improve appearance, without treatment of a related illness or injury.

Covered Services
A specific dental service or item, which is dentally necessary and covered under the Plan, as specifically described in this Summary.

Customary Restorative Materials
Amalgam (silver fillings), glass ionomer and intraorally cured acrylic resin and resin-based composite materials (white fillings).

Date of Service
Generally the date the dental service is performed. For prosthetic or other special restorative procedures, the date of service is the date impressions were made for final working models. For endodontic procedures, date of service is the date on which the root canal was first entered for the purpose of canal preparation.

Deductible
The amount you must pay toward the Allowed Amount for certain covered services each year before the Claims Administrator begins to pay benefits.

Dentally Necessary
Care that is limited to diagnostic examination, treatment, and the use of dental equipment and appliances and is required to prevent deterioration of dental health or to restore dental function. The covered Member's general health condition must permit the necessary procedure(s). Decisions about dental necessity are made by the Claims Administrator's dental directors or their designees, subject to final coverage determination by the Plan Sponsor.

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

6. Definitions

Elective Procedures
Procedures available to Members but not dentally necessary.

Emergency Dental Care
Services for an acute dental condition that would lead a prudent layperson to reasonably expect that the absence of immediate care would result in serious impairment to the dentition or would place the Member's oral health in serious jeopardy.

Employee
A person who is eligible as specified by the employer.

Endodontics
Treatment of diseases of the dental pulp. Endodontics includes root canal therapy, pulp-capping procedures, apexification and periapical procedures associated with root canal treatment.

In-Network
A group of participating providers under contract with a Claims Administrator to provide services to Members of the Plan. Alternatively, the services received from network providers.

Investigational
As determined by the Claims Administrator, a drug, device, or dental treatment or procedure is investigational if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes.

Members
Eligible employees and their dependents who are enrolled in the Plan.

Nonparticipating Provider
Providers who have not signed an agreement with the Claims Administrator or its subsidiaries.

Oral Surgery
Routine surgery involving teeth or alveolar bone, including extraction and alveolectomy. Oral surgery may include other oral treatment and surgery if a dentist considers it dentally necessary. Oral surgery does not include orthodontia, orthognathic surgery, placement of dental implants, or surgical care that is necessary because of a medical condition.

Orthodontics
Dental care for the prevention or correction of malocclusion of teeth and dental or facial disharmonies using appliances and techniques that alter the position of teeth in the jaws, including:

1. Limited Orthodontics. This is treatment with a limited objective, not involving the entire dentition.
2. Interceptive Orthodontics. This is treatment that is performed to lessen the severity or future effects of a malformation. Treatment may occur in the primary or transitional dentition.
3. Comprehensive Orthodontics. This includes multiple phases of treatment provided at different stages of development.

Orthognathic Surgery
Oral surgery to alter the position of the jaw bones.

Out-of-Network Care
Care received from a Nonparticipating Provider.

Periodontics
Non-surgical and surgical treatment of diseases of the gingival (gums) and bone supporting the teeth.

Plan
The plan of benefits established by the Plan Sponsor.

6. Definitions

Plan Comparison Chart
A chart in the beginning of this Summary of Benefits that lists specific benefit amounts for covered services.

Plan Sponsor
Board of Regents, University of Minnesota.

Plan Year
The period from the effective date on January 1 to the end of the year on December 31.

Pre-Treatment Estimate of Benefits
The Claims Administrator's review and approval of a proposed treatment plan prior to treatment to estimate the amount of payment if your dental treatment involves major restorative, periodontic, prosthetic, or orthodontic care. The Pre-Treatment estimate will outline the Member's responsibility to the dentist with regard to deductibles, coinsurance, and non-covered services and allow the dentist and the Member to make any necessary financial arrangements before treatment begins.

Prosthetic Services
Services to replace missing teeth, including the prescribing, repair, construction, replacement, and fitting of fixed bridges and full or partial removable dentures. Also included is the surgical placement of dental implants, crowns on implants, and dental prosthetics appliances retained by dental implants.

Provider
Any person, facility, or other program that provides covered services within the scope of the provider's license, certification, registration, or training.

Social Security Disability
Total disability as determined by the Social Security Administration.

Spouse
Person to whom the employee is legally married.

Treatment
The management and care of a Member for the purpose of combating an illness. Treatment includes dental and surgical care, diagnostic evaluation, giving dental advice, monitoring, and taking medication.

You or Your
The employee named on the identification (ID) card and any covered dependents.

7. Coordination of Benefits

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

A. Definitions

These definitions apply only to this section.

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

   a) Group insurance or group-type coverage, whether insured or uninsured; this includes prepayment, group practice, individual practice coverage, and group coverage other than school accident-type coverage.

   b) Coverage under a government plan or one required or provided by law.

   "Plan" does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). "Plan" does not include Medicare (Title XVIII, United States Code, as amended from time to time) for Medicare benefits paid or payable to any person for whom Medicare is primary. "Plan" does not include any benefits that, by law, are excess to any private or other nongovernmental program.

2. "This Plan" means the part of the Plan that provides health care benefits.

3. "Primary plan/secondary plan" is determined by the Order of Benefits Rules. When this Plan is a primary plan, its benefits are determined before any other plan and without considering the other plan's benefits. When this Plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When you are covered under more than two plans, this Plan may be a primary plan to some plans and may be a secondary plan to other plans.

4. "Allowable expense" means the necessary, reasonable, and customary items of expense for health care, covered at least in part by one or more plans covering the person making the claim. "Allowable expense" does not include an item or expense that exceeds benefits that are limited by statute or this Plan.

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

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

B. Order of Benefits Rules

1. **General.** When a claim is filed under this Plan and another plan, this Plan is a secondary plan and determines benefits after the other plan, unless:

   a) The other plan has rules coordinating its benefits with this Plan's benefits; and

   b) The other plan's rules and this Plan's rules require this Plan to be primary.

2. **Rules.** This Plan determines benefits using the first of the following rules that applies:

   a) **Subscriber.** The plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) determines its benefits before the plan that covers the person as a dependent.

7. Coordination of Benefits

b) **Dependent child of parents not divorced.** When this Plan and another plan cover the same child as a dependent of different persons, called "parents":

i) The plan that covers the parent whose birthday falls earlier in the year determines benefits before the plan that covers the parent whose birthday falls later in the year; but

ii) If both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time.

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

c) Dependent child of divorced parents. If two or more plans cover a dependent child of divorced parents, the plan determines benefits in this order:

i) First, the plan of the parent with custody of the child;

ii) Then, the plan that covers the spouse of the parent with custody of the child;

iii) Finally, the plan that covers the parent not having custody of the child.

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

d) **Active/inactive employee.** The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) determines benefits before a plan that covers that person as a laid off or retired employee (or as that employee's dependent). This rule will not apply unless the other plan has the same rule.

e) **Longer/shorter length of coverage.** If none of the above rules determines the order of benefits, the plan that has covered an employee, member, or subscriber longer determines benefits before the plan that has covered that person for the shorter time.

C. Effect on Benefits of This Plan

1. When **B. Order of Benefits Rules** requires this Plan to be a secondary plan, this part applies. Benefits of this Plan may be reduced.

2. Reduction in this Plan's benefits takes place when the sum of a) and b) below exceeds those allowable expenses in a claim determination period. In that case, the benefits of the dental portion of this Plan are reduced so that benefits payable under all plans do not exceed allowable expenses. For the prescription drug portion, benefits payable under this Plan are reduced so that benefits do not exceed allowable expenses less any Plan prescription copays. When benefits of this Plan are reduced, each benefit is reduced in proportion and charged against any applicable benefit limit of this Plan.

   a) The benefits payable for allowable expenses under this Plan, without applying coordination of benefits, and

   b) The benefits payable for allowable expenses under the other plans, without applying coordination of benefits or a similar provision, whether or not claim is made.

7. Coordination of Benefits

D. Right to Receive and Release Needed Information

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

E. Facility of Payment

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

F. Right of Recovery

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

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

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

8. Disputing a Determination Concerning Eligibility, Enrollment, Other Administrative Issue, or Pre-Treatment Estimate of Benefits

If it is determined that your services will not be covered under the Plan, or are only partially covered, due to an eligibility, enrollment, other administrative issue, or Pre-Treatment estimate of benefits, you are entitled to file a request for review. You must follow the procedures listed below:

A1. Dental Claims Administrator Review and Appeal Process

Call or write your Claims Administrator Member Services Department, using the appropriate phone number listed on your dental ID card, for any concerns about a claim that has not been approved through a Pre-Treatment estimate. You must contact the Claims Administrator within 90 days of the date you were notified that the claim would not be approved. The representative will first assist you in trying to resolve the concern informally.

If you are unable to resolve your concern informally, a written request for review, including the reasons you believe you are entitled to have your claim approved, plus supporting documentation, can be submitted to your Claims Administrator. You will receive written notification of the decision from your Claims Administrator within 30 calendar days after Claims Administrator's receipt of your written request for review.

This notice will explain:

- the reason for approval or denial;
- the Plan provisions on which the decision is based;
- any additional material or information needed; and
- the procedure for requesting an appeal

If your question relates to an eligibility, enrollment, or other administrative issue, your Claims Administrator will refer your request to the University of Minnesota Office of Human Resources Contact Center.

8. Disputing a Determination Concerning Eligibility, Enrollment, Other Administrative Issue, or Pre-Treatment Estimate of Benefits

A2. Office of Human Resources Contact Center Coverage Review Process for Eligibility, Enrollment, or Other Administrative Issues

If you are disputing a determination concerning an eligibility, enrollment, other administrative issue, or a denial on a Pre-Treatment estimate of benefits, you may also contact the University's Office of Human Resources Contact Center directly, by telephone at 612-624-8647, by fax at 612-626-0808, by email at benefits@umn.edu, or by mail to Total Compensation, University of Minnesota, 100 Donhowe Building, 319 15th Avenue SE, Minneapolis, MN 55455-0103. You must contact the Office of Human Resources Contact Center within 90 days of the date that the eligibility, enrollment, or other administrative issue first became apparent.

The Office of Human Resources Contact Center representative will first assist you in trying to resolve the concern on an informal basis. If you are unable to resolve your concern informally, a written request for review, including the concerns you have about your eligibility, enrollment, other administrative issue, or a denial on a Pre-Treatment estimate of benefits, plus supporting documentation. You will receive a telephone or written response from the Office of Human Resources Contact Center as soon as possible, but not later than 30 days following the University's receipt of your request for review.

B. Employee Benefits Review Committee

If you do not agree with the response from the University of Minnesota Office of Human Resources Contact Center, you may request a review by the Employee Benefits Review Committee.

Your request must be in writing and be received by fax (612-626-0808) or by mail at Total Compensation, University of Minnesota, 100 Donhowe Building, 319 15th Avenue SE, Minneapolis, MN, 55455-0103, within 60 days of the denial of your coverage. A written decision will be mailed to you from the Employee Benefits Review Committee within 30 days of the University's receipt of your request for review.

C. Sr. Director of Total Compensation Final Review

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

9. Disputing a Payment Denial

If your claim for benefit payments under the Plan is wholly or partially denied, you are entitled to file a request for review. You must follow the procedures for review of disputed claims that are summarized below:

A. Dental Claims Administrator Review and Appeal Process

Call or write your Claims Administrator Member Services Department using the appropriate phone number listed on your dental ID card. The representative will assist you in trying to resolve the concern on an informal basis.

If you are unable to resolve your concern informally, a written request for review, including the reasons you believe you are entitled to benefits and supporting documentation, can be submitted to your Claims Administrator. You will receive written notification of the decision from your Claims Administrator within 30 calendar days after the Claims Administrator's receipt of your written request for review.

This notice will explain:

- the reason for approval or denial;
- the Plan provisions on which the decision is based;
- any additional material or information needed; and
- the procedure for requesting an Employee Benefits review of denied claim.

9. Disputing a Payment Denial

B. Employee Benefits Review Committee

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

C. Sr. Director of Total Compensation Final Review

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

D. Legal Action

If you have gone through the entire internal claims process, you have the right to file a lawsuit challenging the denial. The claims procedures described above are required by federal law and are designed to ensure that disputes regarding the Plan are decided by the appropriate plan fiduciaries. Therefore, courts almost always require that a claimant exhaust a plan's internal claims procedures before filing suit (both filing the initial claim and appealing a denied claim). If you fail to do so, the court will likely dismiss your lawsuit. In a lawsuit, the court generally will review a decision on appeal based on the evidence and arguments that were presented. Except in rare circumstances, the court will not allow you to introduce new evidence or arguments to support your claim. Thus, you should make sure that everything that you believe supports your position is submitted to the appropriate plan fiduciaries during the claims process.

You may pursue legal action only after you have completed the internal claims process described above. In addition, if you have completed the internal claims process above and want to bring a lawsuit, you must do so within one (1) year of the final denial of your claim. If you want to bring a lawsuit related to the Plan for any reason other than to claim a benefit, you must do so within one (1) year of the act or omission giving rise to the claim. Failure to file a lawsuit within these time periods will cause your rights to expire.

The Plan is governed by the laws of the State of Minnesota. All lawsuits arising under the Plan or relating to the Plan must be submitted to the United States District Court for the District of Minnesota. By participating in the Plan, or by asserting an entitlement to any right or benefit under the Plan, you consent to the United States District Court for the District of Minnesota's exercise of personal jurisdiction over you, and waive any argument that that forum is not a convenient forum in which to resolve the lawsuit.

10. Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how dental information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

If your spouse or any dependents are covered by any of your University-sponsored health plans, please share this notice with them. This notice also applies to their medical information.

A. Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You may ask to see or get a copy of your health and claims records and other health information we have about you. Use the contact information at the end of this notice to send a written request to ask us for this information.
- We will provide a copy or a summary of your health and claims records. We may charge a reasonable, cost-based fee. In very limited cases, we may deny your request. If we deny your request, you may request a review of our decision.

Ask us to correct health and claims records

- You may ask us to correct your health and claims records if you think they are incorrect or incomplete. Use the contact information at the end of this notice to send a written request for a correction or update.
- We may say "no" to your request, but if we do, we will provide you a written explanation about our decision.

Request confidential communications

- You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. If you ask us to use a different address, we will use that address for all general University-sponsored health plan communications. Use the contact information at the end of this notice to send a written request or email to ask us to do this.
- We will accommodate reasonable requests if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You may ask us to **not** use or share certain health information for treatment, payment, or our operations. You may also ask us to **not** use or share your information with family members or others involved in your health care or payment for your care. Use the contact information at the end of this notice to send a written request to ask us to do this.
- We will try to accommodate your request, but we are not required to agree to any request.

Get a list of those with whom we have shared information

- You may ask for a list of the times we have shared your health information, with whom we have shared it, and why. You may ask for a specific time period to be covered by the list, but we will not provide any information that goes back more than six years before your request.
- The list will not include any sharing done at your request or for treatment, payment, health care operations, and certain other cases. We will provide one list free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- To get a list send a written request to the address at the end of this notice.

Get a copy of this notice

- You may ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. Use the contact information at the end of this notice to submit a written request for a paper copy.
- You may also obtain a copy of this notice on our website at humanresources.umn.edu/benefits. The notice is in the Medical Summary of Benefits and the Dental Summary of Benefits.

10. Notice of Privacy Practices

File a complaint if you feel your rights are violated

- You may complain if you feel we have violated your rights. Use the contact information at the end of this notice to make your complaint.
- You may also contact the US Department of Health and Human Services Office for Civil Rights to complain.
- We will not retaliate against you for any complaints you make.

B. Your Choices

For certain health information, you may make choices about what we share. If you have a clear preference for how we share your information in the situations described below, use the contact information at the end of this notice to write us and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

  If you are not able to tell us your preference, for example if you are unconscious or cannot be located, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we will not share your information unless you give us written permission or we meet certain specific conditions:

- Marketing purposes

  The only time we may use or share your information for marketing purposes without your permission is when we have a face-to-face interaction with you, such as talking with you at a University health and benefits fair, or we provide you with a gift of nominal value, such as mailing you a calendar highlighting dates related to your Wellness Program or health plan coverage.

- Sale of your information

  The only time we may share your information in a sales transaction without your permission is when the sale is specifically permitted under the law, such as the sale of an entire business operation

- Psychotherapy notes

  The only time we may use or share your psychotherapy notes without your permission is when the law requires or specifically permits us to do so, when they are an issue in a legal action brought by you, they are related to treatment, payment or healthcare operations, or certain other limited situations, such as oversight of the provider who treated you.

C. Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Help manage the health care treatment you receive

We may use your health information to coordinate your care and share it with professionals who are treating you, but Minnesota law requires that we get your permission before we can do this.

Example: A doctor treating you for an injury requests information about your primary care providers in order to provide appropriate treatment. Minnesota law requires that we get your written consent before we can share this information.

Run our organization

We may use and disclose your information to run our organization, evaluate and enhance our plans, develop program offerings, and contact you. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

Example: We analyze health data to determine how to improve our services, develop plan rates, perform underwriting, and make decisions about enhancements and modifications for future plans and coverage. We share

10. Notice of Privacy Practices

health information with our Claims Administrators and other organizations called "business associates" who help us manage our plans, develop new services and assist in performing the treatment, health care operations and payment functions to administer our plans and services. We use health information about you to suggest particular wellness or disease management programs that could help improve your health.

Pay for your health services

We may use your health information to coordinate payment for your health care, but Minnesota law requires us to get your permission before we may share your health information to pay for your health services.

Example: Minnesota law requires that we get your written consent before we share information about you in order to facilitate payment for your treatment or coordinate benefits with other plans you may have.

Administer your plan

The University of Minnesota sponsors all of the University health plans. Certain of your health information is shared with individuals within the University for purposes of administering the health plans.

Example: We share certain health information within the University, such as information needed to explain the premiums we charge, as well as information about enrollment, disenrollment, and summary health information. Under certain circumstances we may share additional health information for plan administration, provided the recipient agrees to handle the information according to applicable law.

How else can we use or share your health information?

We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We may share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Conduct research

We may use or share your information to conduct research, and may share your information with outside researchers if you do not object.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner

We may share health information about you with organ procurement organizations. We may share health information with a coroner or medical examiner when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We may use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions, such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We may share health information about you in response to a court or administrative order, subpoena, discovery request, or other legal process.

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D. Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information, provide you with this notice, and notify you if there is a breach of any of your unsecured health information. We must follow the duties and privacy practices described in this notice. We will not share your health information in any way that is not described in this notice without getting your permission. Unless we have already taken action on your permission, you may take back or revoke your permission at any time by writing to us using the contact information at the end of this notice.

E. Effective Date and Changes to This Notice

The effective date of this notice is January 1, 2022. We may change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our website at humanresources.umn.edu/benefits. The notice is included in the Medical Summary of Benefits and Dental Summary of Benefits.

This Notice of Privacy Practices applies to health plans sponsored by the University of Minnesota, including:

- Medical Plan, administered by Medica
- Pharmacy Program, administered by Prime Therapeutics and Fairview Specialty Pharmacy
- Medication Therapy Management, administered by the Medica and Network Pharmacies
- Dental Plans, administered by Delta Dental
- Health Care Flexible Spending Accounts, administered by WEX
- Emergency Travel Assistance, administered by Redpoint
- Wellbeing Program, administered by Virgin Pulse, Medica, and the University of Minnesota
- University of Minnesota Employee Assistance Program (EAP), provided by the University of Minnesota and Sand Creek, an AllOne Health Company

F. Contact Information

University of Minnesota

Health Information Privacy & Compliance Office

MMC 501

420 Delaware Street SE

Minneapolis, MN 55455

privacy@umn.edu

612.624.7447

11. COBRA Notice

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

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

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

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

Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You can learn more about many of these options at www.healthcare.gov.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

In addition, in general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

It is important that you choose carefully between COBRA continuation coverage and other coverage options because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

A. Continuation of Coverage

COBRA continuation coverage is a continuation of University benefit coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses and dependent children may be qualified beneficiaries. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage.

1. If you are an employee, you will become a qualified beneficiary if you will lose coverage under the Plan due to one of the following qualifying events:

    a) Your hours of employment are reduced below a 50 to 74 percent time appointment; or

    b) Your employment is terminated for any reason other than gross misconduct.

2. If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events:

    a) Employee dies;

    b) Employee's hours of employment are reduced;

    c) Employee's employment ends for any reason other than their gross misconduct;

    d) Employee retires at age 65 or over and enrolls in Medicare (Part A, Part B); or

    e) Employee divorces.

3. Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because of any of the following qualifying events:

    a) Employee dies;

    b) Employee's hours of employment are reduced;

    c) Employee's employment ends for any reason other than their gross misconduct;

    d) Employee retires at age 65 or over and enrolls in Medicare (Part A, Part B); or

    e) Dependent child is no longer eligible for coverage because they have reached age 26 or has otherwise lost eligibility for the program; or

    f) Employee is divorced.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after Total Compensation has determined that a qualifying event has occurred, such as the end of employment, reduction of hours of employment, death of the employee, or retirement of an employee age 65 or over and enrollment of same employee in Medicare (Part A, Part B, or both). Your coverage will terminate at the end of the month in which a qualifying event has occurred unless you elect COBRA continuation coverage. You have 60 days from the date of loss of coverage or date of the COBRA notice, whichever is later, to elect COBRA continuation coverage.

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Note: For other qualifying events — divorce, legal separation, or a dependent child losing eligibility for coverage — you must notify 121 Benefits within 60 days after the qualifying event occurs. You must either send a letter of notification to: 121 Benefits, 730 2nd Ave S, Suite 400, 730 Building, Minneapolis, MN 55402, or call 121 benefits at 612-887-4321 Option 2, or 1-800-300-1672. 121 Benefits will send you the appropriate form to complete. This form must then be completed and sent to 121 Benefits at the address above, and postmarked within the 60-day time limitation. Your coverage will terminate at the end of the month in which the qualifying event occurs unless you elect COBRA continuation coverage. You have 60 days from the date of loss of coverage or date of the COBRA notice, whichever is later, to elect COBRA continuation coverage.

For each qualified beneficiary who elects COBRA, coverage will begin on the date the University benefit coverage would otherwise have been lost.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

B. Qualifying Events Determine Length of Coverage

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

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

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

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

You must make sure that Total Compensation is notified of the SSA's determination within **60 days** of the latest of:

a) the date of the SSA determination,

b) the date of the qualifying event,

c) the date of the loss of coverage, or

d) the date you are informed of your obligation and the procedure to provide this information, *and* before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the University COBRA Administrator. If you fail to notify Total Compensation in writing and postmarked within the time limit, you will lose your right to extend coverage due to disability. Under this provision, you must also notify Total Compensation within 30 days if the SSA determination is revoked.

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

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

3. Medicare Entitlement

If the qualifying event is your termination of employment or reduction of hours of employment, and you became entitled to Medicare benefits less than 18 months before your qualifying event, COBRA coverage under the Plan's Medical and Dental components for qualified beneficiaries (other than you) who lose coverage as a result of your termination of employment or reduction of hours can last until up to 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if you became entitled to Medicare within 18 months before your termination or reduction of hours.

You must notify Total Compensation in writing within 30 days if, after electing COBRA, you or a family member become entitled to Medicare (Part A, Part B, or both) or become covered under other group health plan coverage. You must follow the notice procedures specified in this notice.

In addition, if you were already entitled to Medicare before electing COBRA, you must notify Total Compensation of the date of your Medicare entitlement.

C. End of COBRA Continuation Coverage

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

1. University of Minnesota no longer provides group insurance to any of its employees.

2. The premium for your continuation coverage is not paid in a timely fashion.

Note: You will have 45 days from the date you elect COBRA continuation coverage in which to make your first premium payment to the University COBRA Administrator. After the first payment, there is a 30-day grace period for all future payments. For example: All regular COBRA continuation payments are due on the first day of the month. If your payment is due on January 1, your payment must be postmarked within 30 days of January 31.

Payments made after the 30-day grace period will be returned to you and all coverage will be cancelled as of the end of the month in which the last regular payment was made.

3. After making your COBRA election, you become covered under another group plan that does not include a pre-existing condition clause that applies to you or eligible dependents.

4. After making your COBRA election, you or your dependents become covered under Medicare (Part A, Part B, or both).

5. A final determination has been made by the Social Security Administration that you are no longer disabled. Termination of coverage is effective in the month that begins more than 30 days after the final determination.

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D. Cost of Continuation Coverage

Generally, each qualified beneficiary is required to pay the full premium amount (employer and employee contributions) for the continuation coverage elected. The amount a qualified beneficiary may be required to pay cannot exceed 102% (or, for certain disability coverage, 150%) of the amount similarly situated active employees pay for that coverage. Your election materials will indicate how to determine the premium amount for COBRA continuation coverage.

E. Keep Your Plan Informed of Address Changes

To protect the rights of you and your family, you should keep Total Compensation informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices sent by you to Total Compensation or to the University COBRA Administrator.

F. Questions About Billing

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

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

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

121 Benefits
730 2nd Ave S, Suite 400
730 Building
Minneapolis, MN 55402
Phone: 612-887-4321, Option 2
Toll Free: 1-800-300-1672

2. University COBRA Administrator — Flexible Spending Account: For billing questions about the flexible spending account, contact:

Office of Human Resources Contact Center
612-624-8647 or 800-756-2363

G. Questions About Coverage

If you have questions about your COBRA coverage, call 612-624-8647 or 800-756-2363 to reach the Office of Human Resources Contact Center, or contact the nearest Regional or District Office of the US Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of the Regional and District EBSA Offices are available through the EBSA website at www.dol.gov/ebsa.

This Summary of Benefits booklet provides a complete description of your dental benefits, their limitations, and exclusions.

If there are any differences between the Guide for Benefits Enrollment and this Summary, the Summary of Benefits will govern.

The University of Minnesota shall provide equal access to and opportunity in its programs, facilities, and employment without regard to race, color, creed, religion, national origin, gender, age, marital status, disability, public assistance status, veteran status, sexual orientation, gender identity, or gender expression.

Inquiries regarding compliance may be directed to the Director, Office of Equal Opportunity and Affirmative Action, University of Minnesota, 274 McNamara Alumni Center, 200 Oak Street S.E., Minneapolis, MN 55455, (612) 624-9547, eoaa@umn.edu. Website at eoaa.umn.edu.

This publication/material is available in alternative formats upon request. Please contact Nora Hayes, Office of Human Resources, nhayes@umn.edu or 612-624-8678.

Office of Human Resources
University of Minnesota
Driven to Discover®

Total Compensation
100 Donhowe
319 15th Avenue SE
Minneapolis, MN 55455-0103

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