Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association

Preferred Individual Dental Coverage Contract

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

READ THE CONTRACT CAREFULLY FOR DETAILS ON THE DENTAL COVERAGE.

This contract is a legal contract between you and Blue Cross and Blue Shield of Minnesota.

Right to Cancel

You may cancel this contract by delivering or mailing a written notice to:

Blue Cross and Blue Shield of Minnesota
P.O. Box 982801
El Paso, Texas 79998-2801

You may also deliver or mail a written notice to your Blue Cross and Blue Shield of Minnesota ("Blue Cross") Agent. In addition, you must return the contract before midnight of the 10th day after the date you receive the contract.

All materials must be properly addressed and postage prepaid. The contract will then be considered void from the beginning. Blue Cross must return all payments (including any fees or charges if applicable) made for this contract within 10 days after receiving notice of cancellation and the returned contract.

This Contract is Conditionally Renewable

This contract is renewable for one year terms as long as full premium is paid when due unless one of the reasons detailed under the "Renewal of This Contract" or "Termination of This Contract" sections occurs. If any one of such reasons occurs, Blue Cross reserves the right to not renew or to terminate the contract. Premiums may change at contract renewal as detailed in the "Renewal of This Contract" section.

Agreement and Consideration

In consideration of payment of all premiums when due and receipt of accurate and complete application information, Blue Cross will provide coverage to those eligible covered persons enrolled by the contractholder for dental benefits in accordance with the terms and conditions of this contract. Coverage will begin at 12:00 AM on the effective date. It will remain in force until the first renewal date, and for such further periods for which it is renewed.

Language Access Services

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

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

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

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

နမ့်ကတိၤကညီကျိာ်ဒီး, တ၊်ကဟ့ဉ်နၤကျိာ်တ၊်မၤစ၊ၤကလိတဖဉ်နှဉ်လီၤ. ကိး 1-866-251-6744 လ၊ TTY အဂိၢ်, ကိး 711 တက့၊်.

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

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

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

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

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

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

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

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

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

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

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

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

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

Notice of Nondiscrimination Practices

Effective July 18, 2016

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

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

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

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

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

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

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

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

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

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

Acceptance of the Contract

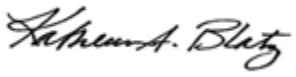
Payment to Blue Cross by the contractholder will signify the contractholder's acceptance of all terms, conditions, and obligations of this contract. Acceptance will be effective on the effective date of this contract.

Independent Corporation

Contractholder hereby expressly acknowledge their understanding that this agreement constitutes a contract solely between contractholder and Blue Cross, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Blue Cross to use the Blue Cross and Blue Shield Service Marks in the state of Minnesota, and that Blue Cross is not contracting as the agent of the Association. Contractholder further acknowledges and agrees that they have not entered into agreement based upon representations by any person other than Blue Cross and that no person, entity, or organization other than Blue Cross shall be accountable or liable to contractholder for any of Blue Cross' obligations to contractholder created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross other than those obligations created under the provisions of this agreement.

Please read the copy of the application attached to your contract. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to us within 10 days if any information shown on the application is not correct and complete or if any information has not been included. The application is part of the contract. The contract was issued on the basis that the answers to all questions and any other material information shown on the application are correct and complete. This agreement is a legal agreement between the contractholder and Blue Cross.

NOTE: This contract cannot be canceled due to an individual's claims experience or health status. Please refer to the "Renewal of This Contract" and "Termination of This Contract" sections.



Kathleen A. Blatz
Interim President and CEO

Jay Matushak
Senior Vice President Chief Financial Officer and Assistant Secretary

Questions?

Call Us

Our customer service staff is available to answer your questions.

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

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

Hours are subject to change without prior notice.

Customer Service Telephone Number	For claims and benefit inquiries call 1-888-589-2447. For all other inquiries such as member (ID) cards, call 1-800-531-6685.
Interpreter Services	See Section "Language Access Services" on page 2.

Visit Us

Our staff is available to answer your questions in person.

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

Hours are subject to change without prior notice.

Edina
Yorkdale Shoppes
6807 York Avenue South
Edina, MN 55435
952-967-2750
TDD/TTY users call 711

Roseville
Crossroads of Roseville
1647B County Road B2 West
Roseville, MN 55113
651-726-1100
TDD/TTY users call 711

Duluth
425 W. Superior Street, Suite 1060
Duluth, MN 55802
218-529-9199
TDD/TYY users call 711

Virginia
1301 West Chestnut Street
Virginia, MN 55972
218-748-2700
TDD/TYY users call 711

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

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

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

Table of Contents

Welcome to Blue Cross

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

This is your dental plan contract. This contract replaces all other contracts you have received from us before the effective date.

In this contract, "you" or “your" refers to the contractholder named on the identification (ID) card and their covered dependents. Contractholder is the person for whom we have provided coverage. Dependent is a covered dependent of the contractholder. All coverage for dependents and all references to dependents in this contract are inapplicable for single coverage. “We”, “our”, or “us” refers to Blue Cross.

This contract explains your dental plan, eligibility, notification procedures, and services and/or expenses that are covered and not covered. It is important that you read the entire contract carefully. It provides you with the information you need to understand your Blue Cross dental plan.

Blue Cross is the insurer and the claims administrator. This contract is a fully insured dental contract designed solely to provide dental care. Coverage is subject to all terms and conditions of this contract, including dental necessity, medical necessity, and appropriateness.

If you have questions about your coverage, please contact our customer service department at the toll-free telephone number listed on the back of your member ID or visit one of our Customer Service locations listed in section “Questions?.”

You can also log onto your Blue Cross member website at www.bluecrossmnonline.com.

Thank you for choosing Blue Cross.

Your Benefits

This contract outlines the dental coverage under this plan.

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

Dental care providers are not beneficiaries under this contract.

All coverage of benefits for dependents and all references to dependents in this contract are not applicable for contractholder only coverage.

Covered Services

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

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

Pre-Determination

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

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

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

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

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

Schedule of Benefits

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

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

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

Deductibles and Maximums

Applies to the combination of services received from Participating Providers (in-network) and Nonparticipating Providers (out-of-network) **The Plan Pays Up To**	
Calendar Year Deductible	$50 per member Excludes Services Covered at 100%
Calendar Year Maximum	$1,000 per member

Class I - Diagnostic/Preventive Services

Benefit Category	Participating Provider (In-Network) The Plan Pays	Nonparticipating Provider (Out-of-Network) The Plan Pays	Waiting Period
Exams (Oral Evaluations)	100%	80%	None
X-rays	100%	80%	None
Cleanings (Prophylaxis)	100%	80%	None
Fluoride Treatments	100%	80%	None
Sealants	100%	80%	None
Palliative Treatment (Emergency)	100%	80%	None

Class I - Diagnostic/Preventive Services Limitations

Benefit Category	Limitations
Exams (Oral Evaluations)	• Comprehensive and periodic – two (2) services per 12 months and one (1) comprehensive service per three (3) year period. • Limited problem focused and consultations – one (1) of these services per Dentist, per patient, per 12 months. • Detailed problem focused – one (1) per patient, per Dentist, per 12 months.
X-rays	• Full mouth x-rays – one (1) every five (5) years. • Bitewing x-rays – one (1) set per 12 months under age 19; 1 (one) set per 18 months age 19 and older. • Intraoral films: ▪ Periapical - four (4) per 12 months ▪ Occlusal – two (2) per 12 months under age eight (8).
Cleanings (Prophylaxis)	Two (2) per 12 months.
Fluoride treatment	Topical application, one (1) per 12 months under age 14.
Sealants	One (1) per tooth, per three (3) years under age 16 on permanent first and second molars.
Palliative treatment (Emergency)	Two (2) per 12 months in combination with pulpal debridement.

Class II - Basic Services

Benefit Category	Participating Provider (In-Network) The Plan Pays	Nonparticipating Provider (Out-of-Network) The Plan Pays	Waiting Period
Basic Restorative	80%	60%	6 Months
Space Maintainers	80%	60%	6 Months
Simple Extractions	80%	60%	6 Months

Benefit Category	Participating Provider (In-Network) The Plan Pays	Nonparticipating Provider (Out-of-Network) The Plan Pays	Waiting Period
Complex Oral Surgery	80%	60%	12 Months
General Anesthesia (nitrous oxide/IV sedation)	80%	60%	12 Months
Repairs and Replacement	80%	60%	6 Months
Surgical/Non-Surgical Periodontics	80%	60%	12 Months
Endodontics	80%	60%	12 Months

Class II - Basic Services Limitations

Benefit Category	Limitations
Basic Restorative:	• Basic restorations - one (1) in 24 months per tooth • Buildup, post and core – one (1) within five (5) years of previous placement of any of the procedures in this category.
Space maintainers	One (1) per tooth, per five (5) year period for covered persons under age 14, only eligible on primary molars and permanent first molars.
General anesthesia and IV sedation	Cannot exceed a total of 60 minutes per session. • Inhalation of nitrous oxide for covered persons under age 13. • Non-intravenous conscious sedation for covered persons under age 13 when medically necessary.
Repairs and Replacement	Restorative services only when they are not, and cannot be made, serviceable: • Prefabricated stainless steel crowns – one (1) per tooth, per lifetime for covered persons under age 14. • Denture relining, rebasing or adjustments are considered part of the denture charges if provided within six (6) months of the insertion of an initial or replacement by the same Dentist. Subsequent denture relining or rebasing limited to one (1) every three (3) years thereafter. • Recementation – one (1) per three (3) years, but within 12 months of the placement of a prosthetic or previous recementation by the same provider is integral.
Surgical/Non-Surgical Periodontal Services	• Full mouth debridement – one (1) per lifetime. • Periodontal maintenance following active periodontal therapy – two (2) per 12 months in addition to routine prophylaxis. • Periodontal scaling and root planing – one (1) per 24 months, per area of the mouth. • Surgical periodontal procedures – one (1) per 36 months, per area of the mouth. • Guided tissue regeneration – one (1) per tooth, per lifetime.
Endodontics	• Root canal retreatment – one (1) per tooth, per lifetime. • Pulpal therapy – one (1) per tooth, per lifetime, only eligible on primary teeth when there is no permanent tooth to replace the primary tooth being treated.

Class III - Major Services

Benefit Category	Participating Provider (In-Network) The Plan Pays	Nonparticipating Provider (Out-of-Network) The Plan Pays	Waiting Period
Inlays, Onlays, Crowns	50%	50%	12 Months
Prosthetics	50%	50%	12 Months
Temporomandibular Disorder/ Reconstructive Surgery	50%	50%	12 Months

Class III - Major Services Limitations

Benefit Category	Limitations
Single crowns, inlays, onlays	One (1) within five (5) years of previous placement of any of the procedures in this category.
Prosthetics	Replacement of natural tooth/teeth in an arch – one (1) within five (5) years of a fixed partial denture, full denture or partial removable denture.
Reconstructive Surgery	• Congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment) only when related to services that are scheduled or initiated prior to the covered person turning age 19. • Dental reconstructive surgical services when such dental service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent under age 19 because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician.

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

Blue Cross provides access to the United Concordia Advantage Plus 2.0 national network. United Concordia Companies, Inc. is an independent company providing dental benefit management services and access to the Advantage Plus 2.0 network. When you choose an in-network dental provider, you will receive a higher benefit level with the greatest savings.

Services that are not Covered

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

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

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

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

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

Schedule of Exclusions

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

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

The following services, supplies, or charges are excluded.

Services and Procedures

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

Other Expenses and Fees

1 For treatment of fractures and dislocations of the jaw.

2 For treatment of malignancies or neoplasms.

3 For treatment and appliances for bruxism (night grinding of teeth).

4 Elective procedures. For example (but not limited to):
    a. The prophylactic extraction of third molars.

5 For prescription and non-prescription drugs, vitamins or dietary supplements.

6 For house or hospital calls for dental services and for hospitalization costs (facility-use fees).

7 Incomplete treatment. For example (but not limited to):

   a. Covered person does not return to complete treatment; and
   b. Temporary services (for example but not limited to, temporary restorations).

8 Procedures that are:

   a. Part of a service but are reported as separate services or;
   b. Reported in a treatment sequence that is not appropriate or;
   c. Misreported or;
   d. Represent a procedure other than the one reported.

9 Specialized procedures and techniques. For example (but not limited to):

   a. Precision attachments; and
   b. Copings and intentional root canal treatment.

10 Which are cosmetic in nature as determined by Blue Cross. For example (but not limited to):

   a. Bleaching;
   b. Veneer facings;
   c. Personalization or characterization of crowns; and
   d. Bridges and/or dentures.

11 Treatment, services or supplies which are not dentally necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of Blue Cross will apply.

12 Fees for failure to keep scheduled visits.

13 Charges for furnishing medical and dental records or reports and associated delivery charges.

14 Services that are prohibited by law or regulation.

15 Services which are not within the scope of licensure or certification of a provider.

16 Treatment, services or supplies that are provided at no charge.

Miscellaneous

1 Services or procedures started prior to the covered person’s effective date or after the termination date of coverage under this contract. For example multi-visit procedures such as (but not limited to):

   a. Endodontics;
   b. Crowns;
   c. Bridges;
   d. Inlays;
   e. Onlays; and
   f. Dentures.

2 Any claims submitted to Blue Cross by the covered person or on behalf of the covered person in excess of twelve (12) months after the date of service.

3 Services that are provided for the treatment of an employment related injury for which you are entitled to make a worker's compensation claim unless the worker's compensation carrier has disputed the claim.

4 Charges that are eligible, paid or payable under any medical payment automobile personal injury protection that is payable without regard to fault, including charges for services that are applied toward any deductible, copay, or coinsurance requirement of such a policy.

5 For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

Choice of Provider

You may choose any licensed dental care provider for services.

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

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

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

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

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

Payment of Benefits

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

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

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

Participating Provider

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

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

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

Nonparticipating Provider

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

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

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

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

Who is Eligible for Coverage

Eligible Dependents

You and your dependents must meet the eligibility requirements of this contract and any additional eligibility requirements that may be imposed by law or regulation.

We must receive information about you and your dependents, the selected dental product, payment method, and billing frequency.

Coverage will begin on the first day of the month following receipt of a completed enrolment form except as outlined below.

We reserve the right to require proof of dependents.

You, your spouse, and/or dependents can be covered under only one (1) dental contract issued by us at the contractholder's option.

Your Spouse

Your spouse is:

1. The person to whom you are legally married.
2. Your domestic partner. A domestic partner is an adult whom you are in a committed and mutually exclusive relationship with and with whom you are jointly responsible for each other's welfare and financial obligations.

   Your partner must:

   a. Be at least 18 years of age and unmarried,
   b. Be mentally competent,
   c. Not be your blood relative, and
   d. Reside with you in the same principal residence and intends to do so permanently.

Your Dependent Children

Dependent Children up to the limiting age.

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

Adding New Dependents

We require payment of any required premiums and completion of our enrollment form to add a new dependent.

New dependents can be added to the contract at the renewal date of the contract.

Adding a Dependent Child Outside of the Renewal Date

Outside of the renewal date, dependents may be added to the contract in certain circumstances. You must notify us within 60 calendar days of the occurrence of one of the following events.

Event	Effective Date
• Birth • Adopted or Placed within 31 days of birth	Date of Birth
• Adopted or Placed 32 days or greater from birth	Date of adoption or placement
• Court Ordered	First day of the month following receipt of enrollment information
• Adding a Dependent Under Age Three (3)	Children may be added to the plan at the time you originally become effective or anytime up to 30 days following the child's 3rd birthday.

Adding a Disabled Dependent

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

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

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

Premium Payment

Premiums for your coverage must be prepaid. The premium rate(s) are payable and must be paid by the due date shown on the bill. Premium must be paid timely and in full. The frequency and payment method are chosen at the time of purchase.

From time to time, Blue Cross may change the rate tables used for premium calculation. Premiums will be based on the rates in effect on the contract's renewal date.

Blue Cross will make no change in premium solely because of claims made under this contract.

Premiums may change at renewal and will remain the same for one year. However, some changes may result in a rate change.

1. Adding new dependents
2. A change to your permanent home address

Blue Cross reserves the right to seek reimbursement from the contractholder for any bank charges incurred for insufficient funds on a payment by the contractholder.

Grace Period

After your first premium payment, if premium is not paid by the due date indicated on the bill, we allow thirty-one (31) calendar days "grace period" for payment of the overdue premium.

The grace period starts on the day after the initial due date for the payment period. You are covered during this grace period provided payment of your premium is made by the end of the grace period.

If we do not receive payment by the end of the grace period, your contract will be terminated retroactively to the date to which coverage has been paid. Any claims incurred after the termination date are not eligible for coverage.

Reinstatement

You can request for your contract to be reinstated in writing, over the phone or by sending all required premium(s) to pay you to the current month. Your request must be received within 63 calendar days from your termination date.

If approved, your contract will be reinstated as of the date your contract was terminated. Coverage will be reinstated for the contractholder and all covered dependents. All required premium(s) must be received and you must be paid to the current month to be reinstated.

If your request is not approved, we will notify you in writing of our decision. A refund will be processed separately, if applicable.

Renewal of This Contract

This contract is in effect for twelve (12) months beginning at 12:00 AM on the effective date. The contract shall renew from year to year if premiums are paid timely and in full.

We will provide at least sixty (60) days advance notice of any change in premium at renewal. You accept our renewal by paying monthly premiums when due.

You may change dental plans at renewal. Any applicable waiting periods in the new plan selected will be credited for the amount of time that you have been enrolled in the contract. Any change in premium will be included on the next bill.

No benefits will be paid for expenses incurred during any period of time for which premium has not been paid.

You may choose not to renew your contract with us by notifying us in writing.

If we decide not to renew your contract, we will give a sixty (60) days advance notice.

Termination of This Contract

During the course of your coverage or a continuation period, if your marital status changes or a dependent ceases to be an eligible dependent under the terms of this contract, you or your dependent must notify us in writing. In addition, you must notify us if a disabled dependent is no longer disabled.

You must provide notification to us within 60 days of changes in you or your dependent's eligibility to obtain continuation of coverage options. Refer to the "Continuation Coverage" section for information regarding extension of coverage.

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

Important Note: If we cancel this contract, coverage will be cancelled for the contractholder and all covered dependents. We refund any unearned premiums in the event of cancellation of this contract.

Contractholder Request Termination

You may cancel this contract or coverage for any dependent at any time by giving us advance signed written notice.

In the event a specific cancellation date is provided, coverage will be terminated per the following:

1. When the requested cancellation date is prior to the date the cancellation notice was received by Blue Cross, the cancel date will be the first of the following month in which Blue Cross received the request.
2. When the requested cancellation date precedes the date the cancellation notice was received by Blue Cross and is not the first of the month, the cancel date will be the first of the following month from the requested date.
3. When the requested cancellation date precedes the date the cancellation notice was received by Blue Cross and is the first of the month, the cancel date will be the requested date.

In the event a specific cancellation date is not provided, coverage will be terminated the first of the following month in which Blue Cross receive the request.

Termination for Fraudulent Practices

We have the right to cancel, decline to issue, or fail to renew this contract, including retroactively for you and/or your dependent(s) if you and/or your dependent(s) engage in fraud of any type or intentional misrepresentation of material fact including, but not limited to:

1. Submitting fraudulent misstatements or omissions about your dental history or eligibility status on the enrollment form for coverage You no longer reside or live in the state of Minnesota.
2. Submitting fraudulent, altered, or duplicate billings for personal gain, or
3. Allowing another party not eligible for coverage under the contract to use your and/or your dependent's coverage.

Other Termination Reasons

We have the right to cancel, decline to issue, or fail to renew this contract, including retroactively, if any of the following occurs:

1. You fail to complete and return information requested by Blue Cross in connection with confirming your eligibility.
2. You no longer reside or live in the state of Minnesota.
3. Your dependent loss eligibility and did not elect to continue coverage. Coverage will terminate only for the dependent no longer eligible.
4. Blue Cross ceases to renew all contracts issued on this form to residents of the state where the contractholder lives.
5. We may terminate the contract for nonpayment of premiums when due, subject to the grace period provision.
6. The contractholder dies. Surviving dependents may be eligible for continuation coverage as specified in the section titled "Continuation Coverage."

Effect of Termination

The contractholder and/or dependents will not be able to re-enroll himself/herself for three (3) years from the cancel date from this contract (the “Lock-out Period”).

This includes:

1. The contractholder voluntarily cancelling the contract and or coverage for a dependent at renewal or on any other date.
2. The contract is canceled for fraud, material misrepresentation, or non-payment of premium.

Upon re-enrollment, waiting periods will apply before the contractholder and or dependent is eligible for benefits under the new contract.

Benefits After Coverage Cancels

We are not liable to pay any benefits for covered services that are started after your cancel date.

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

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

Continuation Coverage

Coverage for all dependents will end on the date the contractholder's coverage ends or the date when the dependent is no longer eligible for coverage. Dependents may continue coverage under this contract if coverage ends because of any of the qualifying events listed below. A spouse and or dependent children not covered at the time of the contractholder’s death is not eligible to elect continuation coverage.

In all cases, continuation ends in the event this contract is canceled as specified in the section "Termination of This Contract."

Qualifying Events

Qualifying Event	Who May Continue	Maximum Continuation Period
Divorce or legal separation	Ex-spouse/spouse and any dependent children that lose coverage	Date coverage would otherwise end.
Death of contractholder	Surviving spouse and dependent children	Earlier of: 1. Enrollment Date in other group coverage, or 2. Date coverage would otherwise end if the contractholder had lived.
Dependents lose eligibility due to the contractholder's enrollment in Medicare	Ex-spouse/spouse who was covered on the day before the entry of a valid decree of dissolution of marriage and any dependent children that lose coverage	Earliest of: 1. 36 months, 2. Enrollment Date in other group coverage, or 3. Date coverage would otherwise end.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, 2. Enrollment Date in other group coverage, or 3. Date coverage would otherwise end.
Contractholder only cancels coverage	All dependents	Date coverage would otherwise end.

Choosing Continuation

Your dependent must notify us in writing to continue coverage. We require your dependent to pay the first continuation premiums at the time of notice, except that surviving dependents of a deceased subscriber have 90 days to pay the first continuation premiums. After this initial grace period, everyone must pay premiums monthly in advance to us to maintain coverage in force.

If you have questions about how to elect continuation coverage, call our Customer Service listed in section “Questions?.”

We must notify the contractholder or eligible dependent of the option to continue coverage within 10 days of receiving notice of a qualifying event. The contractholder or dependent must notify us within 60 days of a qualifying event, such as divorce or legal separation that would result in a loss of coverage for the dependent.

Coordination of Benefits

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

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

Coordination of Benefits Definition

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

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

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

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

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

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

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

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

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

COB Determination Rules

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

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

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

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

COB for You and Your Dependent(s)

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

COB for Your Dependent Children

1. Birthday Rule

a. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year.

b. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.

c. If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent, and if as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.

2. Dependent child and parents are separated or divorce

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

COB for Active/Inactive Member

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

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

Right of Recovery

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

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

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

Reimbursement and Subrogation

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

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

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

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

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

Notice Requirement

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

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

Duty to Cooperate

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

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

Release of Records

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

We may need this information to process:

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

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

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

Claims Process

Notice of Claim

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

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

Claim Forms

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

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

Proof of Loss

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

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

Time Payment of Claims

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

Payment of Claims

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

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

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

Right of Examination

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

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

Review of a Benefit Determination

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

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

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

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

Appeal Process

Appeal Procedures Definitions

The following definitions apply to the appeal procedures:

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

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

Appeal Procedures

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

The request for an appeal should include:

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

Send your Appeal to:

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

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

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

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

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

General Information

Entire Contract

This contract, the application for coverage, identification issued, and any amendments make up the entire contract of coverage. The contractholder hereby expressly acknowledges his/her understanding that this contract constitutes a contract solely between the contractholder and Blue Cross. Please refer to "Independent Corporation" in the front of this contract.

This contract is issued and delivered in the state of Minnesota, it is subject to the substantive laws of the state of Minnesota, without regard to its choice of law principles; and it is not subject to the substantive laws of any other state. Blue Cross does not issue individual coverage, such as this contract, through any arrangement with an employer. Blue Cross is not responsible for any action taken by an employer that results in this coverage being considered group coverage under state or federal law. The employer is solely responsible for any such finding.

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

Time Limit for Misstatements

We issue this contract based on the statements you made on your application. If your application contained misstatements or falsifications that affected our approval of your application, we may rescind the coverage, deny payment of claims, or ask you to sign a rider to continue the coverage.

We will provide at least 30 days advance written notice to each individual who would be affected by the proposed rescission of coverage before coverage under the dental plan may be terminated retroactively.

After your coverage is in force for two (2) years, no statements made on your application, except those made in fraud, are used to void your contract or to deny a claim for care that starts after the end of the two (2) year period.

Indemnity for Loss of Life

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured. This provision does not apply to the coverage available under this contract. This contract only provides coverage of benefits for dental services as outlined in the “Schedule of Benefits” and “Schedule of Exclusions.”

Change of Beneficiary

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

Assignment

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

Legal Actions

No action at law or in equity shall be brought to recover on the contract prior to the expiration of sixty (60) days after written proof of loss has been filed in accordance with the requirements of the contract. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

No Third-Party Beneficiaries

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

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

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

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

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

1. the Ryan White HIV/AIDS Program;
2. other Federal and State government programs (or grantees) that provide premium and cost-sharing support for specific individuals; and
3. Indian tribes, tribal organizations, and urban Indian organizations.
4. Small employers that qualify as a Qualified Employer Heath Reimbursement Arrangement (QSEHRA) under the 21st Century Cures Act
5. Employers using a Health Reimbursement Arrangement (HRA) are permitted, to the extent such payments are lawfully funded through an HRA that constitutes a group health plan under applicable regulations, which have not been enjoined by a court of competent jurisdiction. This is known as an Individual Coverage Health Reimbursement Arrangement (ICHRA).

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

“Payments” include those made by any means, for example:

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

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

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

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

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

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

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

If you have questions about this third-party payment policy or whether Blue Cross will accept premium and/or cost-sharing payments made by a specific person or entity, please contact our customer service department at the toll-free telephone number listed in the “Questions?” section or on the back of your member ID.

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

Time Periods

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

Terms You Should Know

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

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

Contract - This document, including riders, schedules, addenda and/or endorsements, if any, which are attached to the contract and describe the dental coverage purchased from Blue Cross.

Contractholder(s) - The individual named on the contract who purchased this dental coverage. Unless otherwise indicated, contractholder must be at least 18 years of age.

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

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

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

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

Effective Date – The date on which the contract begins or the date on which coverage for a covered person begins.

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

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

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

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

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

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

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

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

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

Renewal Date – The date the contract renews.

Schedule of Benefits – The summary of covered services, contract payments, deductibles, Benefit Waiting Periods, and maximums applicable to benefits payable under the contract.

Schedule of Exclusions – The list of exclusions applicable to benefits, services, supplies, or charges under the contract.

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

Waiting Period(s) - A period of time a covered person must be enrolled under the contract before benefits will be paid for certain Covered Services as shown on the "Schedule of Benefits."

Minnesota Life and Health Insurance Guaranty Association Notice

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

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

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

Minnesota Life and Health Insurance Guaranty Association

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

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

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

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