HealthPartners®

# Summary Plan Description

## Bethel University Dental Benefit Plan

## HealthPartners Dental Distinctions Plan

SPD-400.28-SI-HPD-3334-23

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**Amendments, if applicable**

**BENEFITS CHART**


**HealthPartners Dental Distinctions Plan Summary Plan Description**

# SPECIFIC INFORMATION ABOUT THE PLAN

**Summary Plan Description Effective Date: The later of January 1, 2023 and the Covered Person's effective date of coverage under the Plan.**

| | |
|---|---|
| **Employer:** | Bethel University |
| **Name of the Plan:** | The Plan shall be known as the Bethel University Dental Benefit Plan which provides Employee and dependent benefits. |
| **Address of the Plan:** | 2 Pine Tree Drive, Suite 530<br>Arden Hills, MN 55112<br>651-638-6119 |
| **Group Number:** | 3334 |
| **Plan Year:** | The period beginning on each January 1 in which the provisions of the Plan are in effect. |
| **Plan Fiscal Year Ends:** | December 31 |
| **Plan Sponsor:** (is ultimately responsible for the management of the Plan; may employ or contract with persons or firms to perform day-to-day functions such as processing claims and performing other Plan-connected services.) | Bethel University |
| **Agent for Service of Legal Process:** | General Counsel for Bethel University |
| **Named Fiduciary:** (has the authority to control and manage the operation and administration of the Plan; has discretionary authority to determine eligibility for benefits or to construe the terms of the Plan.) | Bethel University |
| **Funding:** | Claims under the Plan are paid from the general assets of the Employer. |
| **Plan Manager:** (provides administrative services to the Plan Sponsor in connection with the operation of the Plan, such as processing of claims and other functions, as may be delegated to it.) | HealthPartners Administrators, Inc.<br>8170 33rd Avenue South, P.O. Box 1309<br>Minneapolis, MN 55440-1309<br>952-883-6000 |
| **Network Providers:** | HealthPartners Network |
| **Contributions:** | Please refer to the most recent enrollment material for information regarding contributions to your Plan which is hereby incorporated by this reference. |

**HEALTHPARTNERS MISSION**

***OUR MISSION IS TO IMPROVE HEALTH AND WELL-BEING IN PARTNERSHIP WITH OUR MEMBERS, PATIENTS AND COMMUNITY.***

## ABOUT HEALTHPARTNERS AND YOUR EMPLOYER

**HealthPartners Administrators, Inc. ("HPAI")**. HPAI ("Plan Manager") is a third party administrator (TPA). All references to "HealthPartners" throughout this SPD mean HPAI.

**Employer ("Plan Sponsor").** The Employer has established a Dental Benefit Plan ("the Plan" and/or "this Plan") to provide dental benefits for Covered Employees and their Covered Dependents ("Covered Persons"). The Plan is "self-insured" which means that the Plan Sponsor pays the claims from its own funding as expenses for Covered Services as they are incurred. The Plan is described in this Summary Plan Description (SPD). The Plan Sponsor has contracted with HPAI to provide access to its Network of dental care providers, claims processing and other Plan administration services. However, the Plan Sponsor is solely responsible for payment of your eligible claims.

**Powers of the Plan Sponsor.** The Plan Sponsor shall have all powers and discretion necessary to administer the Plan, including, without limitation, powers to interpret the provisions of the Plan; establish and revise the method of accounting for the Plan; establish rules and prescribe any forms required for administration of the Plan; change the Plan; and terminate the Plan.

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

The Plan Sponsor shall have the power to delegate specific duties and responsibilities. Any delegation by the Plan Sponsor may allow further delegations by such individuals or entities to whom the delegation has been made. Any delegation may be rescinded by the Plan 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.

**HealthPartners trademarks.** HealthPartners' names and logos and all related products and service names, design marks and slogans are the trademarks of HealthPartners or its related companies.

**No guarantee of employment.** The adoption and maintenance of the Plan shall not be deemed to be a contract of employment between the Plan Sponsor and any Covered Employee. Nothing contained herein shall give any Covered Employee the right to be retained in the employ of the Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge any Covered Employee, any time, nor shall it give the Plan Sponsor the right to require any Covered Employee to remain in its employ or to interfere with the Covered Employee's right to terminate their employment at any time.

## RESPONSIBILITIES OF COVERED PERSONS

- Read this SPD, the Benefits Chart and the enrollment materials completely and comply with the stated rules and limitations
- Contact providers to arrange for necessary dental appointments
- Pay any applicable Deductibles, Coinsurance and contributions as stated in this SPD and the Benefits Chart
- Identify yourself as a Covered Person by presenting your identification card whenever you receive Covered Services under the Plan

## RIGHTS UPON TERMINATION OR AMENDMENT OF THIS PLAN

For a summary of Plan provisions governing benefits, rights and obligations of participants and beneficiaries under the Plan on termination of the Plan or amendment or elimination of benefits under the Plan, please consult your Employer.

# INTRODUCTION TO THE SUMMARY PLAN DESCRIPTION

## SUMMARY PLAN DESCRIPTION (SPD)

This SPD is your description of the Employer's Dental Benefit Plan (the Plan). It describes the Plan's benefits and limitations. Attached to this SPD is a Benefits Chart which is incorporated and fully made a part of this SPD. It describes the amounts of payments and limits for the coverage provided under this SPD. Refer to your Benefits Chart for benefits and the amount of coverage applicable to a particular benefit and a detailed list of exclusions.

This SPD should be read completely. 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. Your SPD should be kept in a safe place for your future reference.

The Plan is maintained exclusively for Covered Employees and their Covered Dependents. Each Covered Person's rights under the Plan are legally enforceable.

The use of any gender-specific terms refer to sex assigned at birth.

Certain capitalized words have special meanings. These words are defined in "Definitions". Additional capitalized terms are defined in the Benefits Chart.

## DENTAL CLAIMS ADMINISTRATIVE SERVICES AGREEMENT (ASA)

This SPD, the Benefits Chart(s), and any Amendments, together with the ASA between the Plan Sponsor and HPAI, as well as any other documents referenced in the ASA, constitute the entire agreement between HPAI and the Plan Sponsor. The ASA is available for inspection at your Employer's office or at HealthPartners' home office, at 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

## IDENTIFICATION CARD

An identification card will be issued to you at the time of enrollment. You will be asked to present your identification card, or otherwise show that you are a Covered Person, whenever you receive services. You may not permit anyone else to use your card to obtain care.

## ASSIGNMENT OF BENEFITS

You may not, in any way, assign or transfer your rights or benefits under the Plan. In addition, you may not, in any way, assign or transfer your right to pursue any causes of action arising under this Plan including, but not limited to, causes of action for denial of benefits under this Plan.

## CONTRIBUTIONS

This SPD is conditioned on regular receipt of Covered Persons' contributions toward the coverage provided by this SPD. The contributions are made through the Plan Sponsor, unless HPAI has agreed to another payment method. Contributions are based upon the plan type and the number and status of any dependents enrolled with the Covered Employee.

## AMENDMENTS TO THIS SPD

Amendments which are included with this SPD or sent to you at a later date are incorporated and fully made a part of this SPD.

## CONFLICT WITH EXISTING LAW

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

## HOW TO USE THE PLAN

This SPD describes your Covered Services and how to obtain them. **The Plan provides both Network Benefits and Out-of-Network Benefits from which you may choose to receive Covered Services each time you need dental care.** Coverage may vary according to your provider selection. The provisions below contain certain information you need to know in order to obtain Network Benefits.

**Network Providers.** These are any of the participating licensed Dentists or other dental care providers or facilities who have entered into an agreement with HealthPartners to provide dental care services to Covered Persons. 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 Network Benefits.

**Network Providers are available to view free of charge by logging on to your "*my*HealthPartners" account at healthpartners.com. If you need assistance locating a Dentist or other dental care providers in your Network, please contact Member Services.**

**Out-of-Network Providers.** These are licensed Dentists or other dental care providers, or facilities not participating as Network Providers. Services received from Out-of-Network Providers will be covered at the Out-of-Network Benefit level. There are limited exceptions as described in this SPD and the Benefits Chart.

## ABOUT THE NETWORK

**To obtain Network Benefits for Covered Services, you must receive services from Network Providers.** There are limited exceptions as described in this SPD and the Benefits Chart. **You must verify that your provider participates with the Network each time you receive services.**

**Network.** These are the dental care providers and facilities contracted to provide services for this Plan.

**Network Dental Clinics.** These are participating clinics providing dental services.

**Second Opinions for Network Services.** If you question a decision by a Network Dentist about dental care, the Plan covers a second opinion from a Network Dentist.

**Referrals and Authorizations for Network Services.** There is no referral requirement for services delivered by providers within your Network. Your Dentist will coordinate the authorization process for any services which must first be authorized.

**Referral.** This is a professional communication unrelated to benefits, introducing a patient to another provider, and requesting their involvement in the patient's care.

The Plan Sponsor or their designee makes coverage determinations and makes final authorization for certain Covered Services. Coverage determinations are based on established dental policies, which are subject to periodic review and modification by the Plan Manager's dental directors or their designees. Certain benefit limitations may be waived upon submission, by your Dentist, of documentation of dental necessity.

Call Member Services at 952-883-5000 or 800-883-2177 for more information on authorization requirements.

## ACCESS TO RECORDS AND CONFIDENTIALITY

The Plan Sponsor complies with applicable state and federal laws governing the confidentiality and use of protected health information and medical or dental records. As part of this SPD, the Plan Sponsor is authorized to have access to and use protected health information held by any health care provider who delivers health care services to you under this SPD. The Plan Sponsor is also allowed to use your protected health information, when necessary, for certain health care operations including, but not limited to, claims processing, quality of care assessment and improvement, accreditation, credentialing, case management, care coordination and utilization management, disease management, underwriting, premium rating, claims experience reporting, the evaluation of potential or actual claims against the Plan Sponsor, auditing and legal services, and other access and use without further authorization if permitted or required by another law.

In the event that protected health information is disclosed to the Plan Sponsor, the Plan Sponsor may only use or disclose such information as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations promulgated thereunder and as amended including certain plan administrative functions such as: claims review, quality assurance, auditing, monitoring and management of carve out plans. Information may only be disclosed to the Plan Sponsor upon receipt, by the Plan, of a certification from the Plan Sponsor to the amendment of the Plan documents and that your Plan Sponsor agrees to:

- Not use or further disclose information except as listed above or as required or permitted by law
- Ensure that any agents or subcontractors agree to the same restrictions and conditions that apply to your Employer or Plan Sponsor and that such agents and subcontractors agree to implement reasonable and appropriate security measures to protect electronic protected health information
- Not use or disclose any information for employment-related actions or decisions
- Not use or disclose any information in connection with any other employee benefit plan of your Employer or Plan Sponsor
- Report to the Plan any security incident it becomes aware of and any use or disclosure of the information that is inconsistent with the uses or disclosures described above
- Make information available to fulfill your right to access your protected health information
- Make the information available for amendment or to incorporate applicable amendments
- Make the information available in order to provide an accounting of disclosures
- Make its internal practices, books and records relating to the use and disclosure of information received from the Plan available to the Department of Health and Human Services to determine compliance with HIPAA
- Return or destroy all protected health information received from the Plan, if feasible, when use or disclosure is no longer required. If return or destruction is not possible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- Ensure only certain classes of Employees designated by your Employer are permitted access to your protected health information for Plan administration functions
- Implement an effective mechanism for handling noncompliance by the Employees designated access to your protected health information
- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic protected health information that is created, received, maintained or transmitted on behalf of the group health plan
- Ensure adequate separation between the Plan and your Plan Sponsor is supported by reasonable and appropriate security measures

**PREDETERMINATION OF BENEFITS**

If a course of treatment is expected to involve Charges for dental services of $300 or more, it is recommended that a description of the procedures to be performed, an estimate of the Dentist's Charges and an appropriate x-ray pertaining to the treatment, be filed by the Dentist with the Plan Manager in writing, prior to the course of treatment.

A "course of treatment" means a planned program of one or more services or supplies, whether rendered by one or more Dentists, for treatment of a dental condition, diagnosed by the attending Dentist as a result of an oral examination. The course of treatment commences on the date a Dentist first renders a service to correct, or treat, such diagnosed dental condition.

Call Member Services for more information on predetermination of benefits.

The Plan Manager will notify the Dentist of the predetermination, based on the course of treatment. In determining the amount the Plan pays, consideration is given to alternate procedures, services, supplies, or courses of treatment, which may be performed for such dental condition. The amount the Plan pays as authorized dental Charges is the appropriate amount determined in accordance with the terms of this SPD and the Benefits Chart.

If a description of the procedures to be performed, and an estimate of the Dentist's Charges are not submitted in advance, the Plan reserves the right to make a determination of benefits payable, taking into account alternate procedures, services, supplies or courses of treatment, based on accepted standards of dental practice.

Predetermination of payment for services to be performed is limited to services performed within 90 days from the date such course of treatment was approved. Additional services required after 90 days must be submitted in writing, as a new course of treatment, and approved on the same basis as the prior plan.

## DEFINITIONS

**Authorized Representative.** This is a person appointed by you to act on your behalf in connection with an initial claim, an appeal of an adverse benefit determination, or both. To designate an authorized representative, you must complete and sign the "Appointment of Authorized Representative" form and return it to the Plan Manager. You should specify on the form the extent of the authorized representative's authority. This form is available by logging on to your "*my*HealthPartners" account at healthpartners.com.

**CareLine℠ Service.** This is a service which employs a staff of registered nurses who are available by phone to assist Covered Persons in assessing their need for dental care, and to coordinate after-hours care, as covered in this SPD and the Benefits Chart.

**Covered Dependent.** This is an Eligible Dependent enrolled in the Plan.

**Covered Employee.** This is an eligible Employee enrolled in the Plan.

**Covered Person.** This is the person covered for benefits and all of their eligible and enrolled dependents. When used in this SPD and the Benefits Chart, "you" or "your" has the same meaning as covered person.

**Covered Service.** This is a specific dental service or item, which is Dentally Necessary and covered under the Plan, as described in this SPD and the Benefits Chart.

**Date of Service.** This is 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.

**Dentist.** This is 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.

**Eligible Dependents.** These are the persons shown below. Under this SPD, a person who is considered a Covered Employee is not qualified as an eligible dependent. A person who is no longer an eligible dependent (as defined below) under the Plan may qualify for continuation of coverage within the group, as provided in the "Continuation of Group Dental Coverage" section of this SPD.

Please note, for Covered Dependents who do not meet the definition of either a "qualifying child" or a "qualifying relative" under Internal Revenue Code Section 152, payments made by your Employer under this Plan for Covered Services may result in taxable income to the Covered Employee. Please consult with your Employer or tax advisor regarding your individual situation.

- **Spouse.** This is a Covered Employee's current legally married opposite gender spouse. If both spouses are covered as Employees under this SPD, only one spouse shall be considered to have any eligible dependents.
- **Child.** This is a Covered Employee's (a) natural or legally adopted child (effective from the date of adoption or the date placed for adoption, whichever is earlier); (b) child for whom the Covered Employee or the Covered Employee's Spouse is the legal guardian; (c) step-child of the Covered Employee (that is, the child of the Covered Employee's Spouse); or (d) a child covered under a valid qualified medical child support order (as the term is defined by applicable law) which is enforceable against a Covered Employee.* In each case the child must be either under 26 years of age or a Disabled Child, as described below. Coverage will terminate the end of the month in which the child turns age 26.

  *A description of the procedures governing qualified medical child support order determinations can be obtained by participants and beneficiaries, without charge, from the Plan Sponsor.
- **Grandchild.** This is a Covered Employee's unmarried grandchild under 19 years of age, or is a full-time student, or is a Disabled Child. An unmarried grandchild who is a full-time student is an eligible dependent until the end of the month in which the grandchild turns age 26. In order to qualify as a dependent, the grandchild must be dependent on the Covered Employee for a majority of their financial support.
- **Full-time student.** This is a Covered Employee's grandchild as referred to in "Grandchild" above, who is enrolled in and attending full-time a recognized course of study or training in a public or private secondary school, college, university, or licensed trade school. Full-time student status continues during regularly scheduled school vacation periods if the dependent meets the eligibility requirements as a full-time student immediately prior to and immediately after the vacation period.

- **Disabled Child.** This is a Covered Employee's dependent Child or Grandchild as defined above, who is (a) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and (b) chiefly dependent on the Covered Employee for support and maintenance. The disability must have come into existence prior to the attainment of the limiting age in Child or Grandchild as described above. The Covered Employee must give the Plan Manager a written request for coverage of a disabled child. The request must include written proof of disability and must be approved by the Plan Manager, in writing. The Plan Manager must receive the request within 31 days of the date an already enrolled dependent becomes eligible for coverage under this definition. The Plan Manager reserves the right to periodically review disability, provided that after the first two years, the Plan Manager will not review the disability more frequently than once every 12 months.

**Employee.** This is a person who is eligible as specified by the Employer.

**Illness.** This is a sickness or disease, including all related conditions and recurrences, requiring Dentally Necessary treatment.

**Injury.** This is an accident to the body, requiring medical or dental treatment.

**Medicare.** This is the federal government's health insurance program under Social Security (Title XVIII). Medicare provides health benefits to people who are age 65 or older, or who are permanently disabled. The program has two parts, Part A and Part B. Part A generally covers the costs of hospitals and extended care facilities. Part B generally covers the costs of professional medical services. Both parts are subject to Medicare deductibles.

## DISPUTES AND COMPLAINTS

### DETERMINATION OF COVERAGE

Eligible services are covered only when Dentally Necessary for the proper treatment of a Covered Person. Frequency limits, Deductibles, Coinsurance, or other maximums or limits for certain Covered Services may not apply for certain medical conditions if you meet specific coverage criteria set by the Plan Manager's dental director. The Plan Manager's dental directors or their designees make coverage determinations of dental necessity, restrictions on access and appropriateness of treatment, however the Plan Sponsor will make final authorization for Covered Services.

### COMPLAINTS

**In general:** The Plan has a complaint procedure to resolve claims and disputes. Complaints should be made in writing or orally. They may concern the provision of care, administrative actions, or claims related to the Plan. The Plan's complaint system is limited to Covered Persons, applicants and former Covered Persons seeking to resolve a dispute which arose during their coverage or application for coverage.

**Complaints must be sent or directed to:**

HealthPartners
Member Services Department
8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: 952-883-5000 or 800-883-2177

## CONDITIONS

### COORDINATION OF BENEFITS

You agree, as a Covered Person, to permit the Plan Manager to coordinate the Plan's obligations under this SPD with payments under any other health or dental benefit plans as specified below, which cover you or your dependents. You also agree to provide any information or submit any claims to other health or dental benefit plans necessary for this purpose. If you fail to provide this information, your claim may be delayed or denied. You agree to authorize the Plan Manager's billing to other health or dental plans, for purposes of coordination of benefits.

1. **Applicability.**
    a. This coordination of benefits (COB) provision applies to this Plan when a Covered Person has health or dental care coverage under more than one plan. "Plan" and "This Plan" are defined below.

b. If this coordination of benefits provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

(1) shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but

(2) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in paragraph 4. below.

**2. Definitions.**

a. **"Plan"** is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This 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).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

b. **"This Plan"** is the part of this SPD that provides benefits for dental care expenses.

c. **"Primary Plan/Secondary Plan"** The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the 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 there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more of the plans and may be a Secondary Plan as to a different plan or plans.

d. **"Allowable Expense"** is a necessary, reasonable and customary item of expense for health or dental care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

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

When benefits are reduced under a primary plan because a Covered Person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

e. **"Claim Determination Period"** is a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

**3. Order of benefit determination rules.**

a. **General.** When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of another plan, unless:

(1) the other plan has rules coordinating its benefits with those of This Plan; and

(2) both those rules and This Plan's rules, in subparagraph b. below, require that This Plan's benefits be determined before those of the other plan.

b. **Rules.** This Plan determines its order of benefits using the first of the following rules which applies:

(1) Nondependent/Dependent. The benefits of the plan which cover the person as a Covered Person or subscriber (that is, other than as a dependent) are determined before those of the plan which cover the person as a dependent.

(2) Dependent Child/Parents not Separated or Divorced. Except as stated in subparagraph b., (3.) below, when This

Plan and another plan cover the same child as a dependent of different persons, called "parents":

(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; but

(b) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described in "(a.)" immediately above, but 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 will determine the order of benefits.

(3) Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) first, the plan of the parent with custody of the child;

(b) then, the plan of the Spouse of the parent with the custody of the child; and

(c) finally, the plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health or dental care expense 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 shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or calendar year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for health or dental care expenses of the child, the plans covering follow the order of benefit determination rules outlined in subparagraph b., 2.

(5) Active/Inactive Employee. The benefits of a plan which covers a person as an Employee who is neither laid off nor retired (or as that Employee's dependent) are determined before those of a plan which cover that person as a laid off or retired employee (or as that Employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(6) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered a Covered Person or subscriber longer are determined before those of the plan which covered that person for the shorter term.

**4. Effect on the benefits of this Plan.**

a. **When this section applies.** This paragraph 4. applies when, in accordance with paragraph 3. "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in b. immediately below.

b. **Reduction in this Plan's benefits.** The benefits of This Plan will be reduced when the sum of:

(1) the benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

(2) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of The Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of The Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

5. **Right to receive and release needed information.** Certain facts are needed to apply these COB rules. The Plan Manager has the right to decide which facts are needed. Consistent with applicable state and federal law, the Plan Manager may get needed facts from or give them to any other organization or person, without your further approval or consent. Unless applicable federal or state law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under This Plan must give any facts the Plan Manager needs to pay the claim.

6. **Facility of payment.** A payment made under another plan may include an amount which should have been paid under This Plan. If it does, the Plan Manager may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan Manager 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.

7. **Right of recovery.** If the amount of the payments made by the Plan is more than should have been paid under this COB provision, the Plan Manager may recover the excess from one or more of:

    a. The persons it has paid or for whom it has paid;
    b. Insurance companies; or
    c. Other organizations.

The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

The benefits provided by This Plan do not apply to Injury or disease covered by no-fault insurance, employers liability laws (including workers’ compensation), and care available or required to be furnished by or through national or state governments or their agencies including care to which a Covered Person is legally entitled and for which facilities are reasonably available for military service-connected conditions or disabilities. The Plan will provide Dentally Necessary services upon request and only pay expenses incurred for dental treatment otherwise covered by This Plan if the no-fault insurer, employer, or national or state government or its agencies refuse to pay said expenses. You must cooperate with the Plan’s program to bill allowable no-fault and workers’ compensation claims to the appropriate insurer(s).

## ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE AND TERMINATION

### ELIGIBILITY

The following persons will be eligible for coverage under this Plan:

1. All Employees, as determined by the Plan Administrator, actively working at least 1,560 hours per year, teaching a 17 TEUs faculty load, or any combination of the above; and

2. Retirees and their spouses less than age 65 and their eligible dependents enrolled in this Plan at time of retirement.

All Employees currently in one of the positions that no longer meet the new benefits eligibility threshold will retain their benefits eligibility status under the old threshold as long as they remain in their current position.

### ENROLLMENT

Employees must enroll themselves and any Eligible Dependents within 31 days of the date they first become eligible. The Employee must enroll a newly acquired dependent (such as a new Spouse) within 31 days of when the new dependent is first acquired.

At your option, you do not have to enroll an Eligible Dependent Child within 31 days of the date the Child first becomes eligible or during the annual open enrollment period if you enroll the Eligible Dependent Child prior to age three. If you elect this option, required payments do not have to be made retroactive to the date of birth, or date of placement for adoption, and coverage is effective on the first of the month following the date of application.

In addition, pursuant to state law, newborn infants (including a newborn Grandchild of a covered grandparent) and a newly adopted child, may be covered, regardless of when notice is received by the Plan Sponsor. However, the Plan Sponsor must receive required payments, if any, from the date of eligibility for a newborn infant (including a newborn Grandchild of a covered grandparent) and a newly adopted child, before benefits will be paid. You must notify the Plan Sponsor immediately of any change in eligibility of a Covered Dependent.

**Late Enrollment.** If you do not enroll yourself or any Eligible Dependents within 31 days of the date that you or your dependents first become eligible (except as specified above), you may enroll yourself and any Eligible Dependents during the annual open enrollment period.

There may be additional situations when you are eligible to enroll yourself and any Eligible Dependents after the first 31 days of eligibility. If you have any questions, contact the Plan Sponsor.

### EFFECTIVE DATE

The Employee's and any dependent's effective date is the date of hire.

### TERMINATION

A Covered Person's coverage under the Plan terminates when any of the following events occur:

1. The contribution for coverage under the Plan is not made by the due date.
2. When a Covered Employee ceases to be eligible under the terms of this Plan, coverage for the Employee and all Covered Dependents terminates on the last day of the month in which the Employee's eligibility ceases, unless group continuation is elected, as described in the "Continuation of Group Dental Coverage" section
3. When a Covered Dependent no longer meets the Plan's definition of Eligible Dependent, coverage for that dependent terminates on the last day of the month in which the dependent's eligibility ceases, unless group continuation is elected, as described in the "Continuation of Group Dental Coverage" section
4. When the maximum period under the group continuation coverage described in the "Continuation of Group Dental Coverage" section expires for the Covered Person
5. When the Plan terminates
6. In the event of misrepresentation or omission of a material fact by the Covered Person regarding eligibility, enrollment, other coverage, claims or other expenses, the Plan Sponsor has the right to rescind this Summary Plan Description or disenroll the Covered Person

To the extent that a termination would be considered a rescission under federal law under terms 2., 3., 4. and 6., the Plan Sponsor is required to give the Covered Person 30 days advance notice of termination.

## CONTINUATION OF GROUP DENTAL COVERAGE

Bethel University will offer a "Continuation of Benefits Coverage" option to Employees who lose coverage. The terms and conditions of this policy will be administered by Bethel University.

## CLAIMS PROVISIONS

### PROCEDURES FOR REIMBURSEMENT OF NETWORK SERVICES

When you present your identification card at the time of requesting Network Benefits from providers, paperwork and submission of claims relating to services will be handled for you by your provider. You may be asked by your provider to sign a form allowing your provider to submit the claim on your behalf. If you receive an invoice or bill from your provider for services, other than Coinsurance or Deductible amounts, simply return the bill or invoice to your provider, noting your enrollment in the Plan. Your provider will then submit the claim under the Plan. Your claim will be processed for payment according to the Employer's coverage guidelines.

## PROCEDURES FOR REIMBURSEMENT OF OUT-OF-NETWORK SERVICES

**Proof of loss.** Claims for Out-of-Network services must be submitted to the Plan Manager at the address shown below. You must submit an itemized bill, which documents the date and type of service, provider name and Charges, for the services incurred. Claims for Out-of-Network services must be submitted within 90 days after the date services were first received for the Injury or Illness upon which the claim is based. Failure to file a claim within this period of time shall not invalidate nor reduce any claim if it was not reasonably possible to file the claim within that time. However, such claim must be filed as soon as reasonably possible and in no event, except in the absence of your legal capacity, later than one year from the date services were first received for the Injury or Illness upon which the claim is based. If the Plan is discontinued, the deadline for claim submission is 180 days. The Plan Manager may request that additional information be submitted, as needed, to make a claim determination.

Send itemized bills to:

Claims Department
HealthPartners
P.O. Box 1172
Minneapolis, MN 55440-1172

**Time of payment of claims.** Benefits will be paid under the Plan within a reasonable time period.

**Payment of claims.** Subject to any written direction of the Covered Employee in the application or otherwise, all or any portion of any benefits provided by this section on account of dental services may, at the Plan Manager's option, unless the Covered Employee requests otherwise in writing (not later than the time of filing proofs of such loss), be paid directly to the Dentist or provider providing such services, but it is not required that the services be provided by a particular Dentist or provider.

All payments for claims will be made directly to the provider of dental services, rather than to the Covered Person, for claims incurred by a Child who is covered as a dependent of a Covered Person who has legal responsibility for the Covered Dependent's dental care pursuant to a court order, provided the Plan Manager is informed of such order. This payment will discharge the Plan Manager from all further liability to the extent of the payment made.

**Information.** When you seek coverage for goods or services under this Plan, you grant the Plan Sponsor the right to collect and review any claims, eligibility, coordination of benefits, or medical or dental information necessary to make a proper determination of coverage under this Plan. In the event you fail to cooperate with or execute any documents necessary for review of coverage requests, the Plan Sponsor reserves the right to refuse to grant coverage without receipt of necessary information.

**Clerical error.** If a clerical error or other mistake occurs, that error does not deprive you of coverage for which you are otherwise eligible nor does it give you coverage under the Plan for which you are not eligible. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverage. Determination of your coverage will be made at the time the claim is reviewed. It is your responsibility to confirm the accuracy of statements made by the Plan Sponsor or the Plan Manager, in accordance with the terms of this SPD and other Plan documents.

## TIME OF NOTIFICATION TO CLAIMANT OF CLAIMS

An initial determination of a claim for benefits must be made by HealthPartners within 30 days. This time period may be extended for an additional 15 days, provided that the Plan Manager determines that such an extension is necessary due to matters beyond the control of the Plan. If such extension is necessary, you will be notified prior to the expiration of the initial 30-day period.

You will receive written notification of any initial adverse claim determination as provided by applicable law.

## CLAIM DENIALS AND CLAIM APPEALS PROCESS

If your claim for benefits under the Plan is wholly or partially denied, you are entitled to appeal that decision. Your Plan provides for two levels of appeal to the Named Fiduciary of your Plan or its delegate. You must exhaust both levels of appeal prior to bringing a civil action. The steps in this appeal process are outlined below.

**First level appeal.** You or your Authorized Representative must file your appeal within 180 days of the adverse decision. Send your written request for review, including comments, documents, records and other information relating to the claim, the reasons you believe you are entitled to benefits, and any supporting documents to:

Member Services Department
HealthPartners
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

The Plan Manager will review your appeal and will notify you of its decision within 30 days.

The time period may be extended if you agree.

All notifications described above will comply with applicable law.

**Final level of appeal to the Plan Sponsor.** If after the first level of appeal, your request was denied, you or your Authorized Representative may, within 180 days of the denial, submit a written appeal for review, including any relevant documents, to the Plan Sponsor and submit issues, comments and additional information as appropriate to:

Bethel University
2 Pine Tree Drive, Suite 530
Arden Hills, MN 55112

The Plan Sponsor will review your appeal and will notify you of its decision within 30 days.

The time period may be extended if you agree.

All notifications described above will comply with applicable law.