HealthPartners Dental Distinctions
Benefits Chart

Effective Date: The later of the effective date of your Employer's Dental Benefit Plan and your effective date of coverage under the Plan.

Coverage for eligible services is subject to the exclusions, limitations and other conditions of this Benefits Chart and the Summary Plan Description (SPD). See the "Services Not Covered" section of the SPD for additional information about exclusions.

The Plan agrees to cover the dental services described below. This Benefits Chart describes the level of payment that applies for each of the covered services. To be covered, dental services or items described below must be dentally necessary. The date of the services must be while you are enrolled in the Plan.

This dental plan allows you to choose, at any time, dentists within the HealthPartners Distinctions Dental Network (Network Benefits) or dentists outside of the Network (Non-Network Benefits).

In addition, Network Providers are divided into two levels. Your deductible and coinsurance under the Network Benefits may vary, depending on what benefit level applies to your Network Provider. Benefit levels are shown below under the Network Benefits. See your provider directory to see what level applies to each Network Provider.

When you use Non-Network Providers, benefits may be substantially reduced and you may incur significantly higher out-of-pocket expenses. A Non-Network Provider does not usually have an agreement with HealthPartners to provide services at a discounted fee. In addition, Non-Network Benefits are restricted to the Plan's maximum amount allowed as described under the definition of "Charge." The Plan's maximum amount allowed can be significantly lower than a Non-Network Provider's billed charges. If the Non-Network Provider's billed charges are over the Plan's maximum amount allowed, you pay the difference, in addition to any required deductible, copayment and/or coinsurance.

The amount that the Plan pays for covered services is listed below. The Covered Person is responsible for the specified dollar amount and/or percentage of charges that the Plan does not pay.

These definitions apply to this Benefits Chart. They also apply to the SPD.

Calendar Year: This is the 12-month period beginning 12:01 A.M. Central Time, on January 1, and ending at midnight Central Time of the next following December 31.

Charge: For covered services delivered by participating Network Providers, this is the provider's discounted charge for a given dental/surgical service, procedure or item, which Network Providers have agreed to accept as payment in full.

For covered services delivered by Non-Network Providers, this is the provider's charge for a given dental/surgical service, procedure or item, up to the Plan's maximum amount allowed for that service, procedure or item, minus any deductible, copayment or coinsurance.

The Plan's maximum amount allowed is based on the usual and customary charge for a given dental/surgical service, procedure or item. This is the maximum amount the Plan considers in the calculation of payment of charges incurred for certain covered services. It is consistent with the charge of other providers of a given service or item in the same region. You must pay for any charges above the maximum amount allowed, and they do not apply to the out-of-pocket limit.

To be covered, a charge must be incurred on or after the Covered Person's effective date and on or before the termination date. For participating Network Provider charges, the amount of the copayment or coinsurance, or the amount applied to the deductible, is based on the agreed fee applicable to the Network Provider, or a reasonable estimate of the cost according to a fee schedule equivalent. For Non-Network Provider charges, the amount considered as a copayment or coinsurance, or the amount applied to the deductible, is based on the lesser of the billed charge and the Plan's maximum amount allowed.

Copayment/Coinsurance: The specified dollar amount, or percentage, of charges incurred for covered services, which the Plan does not pay, but which a Covered Person must pay, each time a Covered Person receives certain dental services, procedures or items. The Plan's payment for those covered services or items begins after the copayment or coinsurance is satisfied. Covered services or items requiring a copayment or coinsurance are specified in this Benefits Chart. For participating Network Provider charges, the amount considered as a copayment or coinsurance is based on the agreed fee applicable to the Network Provider, or a reasonable estimate of the cost according to a fee schedule equivalent. For Non-Network Provider charges, the amount considered as a copayment or coinsurance is based on the lesser of the billed charge and the Plan's maximum amount allowed. A copayment or coinsurance is due at the time a service is rendered, or when billed by the provider.

Deductible: The specified dollar amount of charges incurred for covered services, which the Plan does not pay, but a Covered Person or a family has to pay first in a calendar year. The Plan's payment for those services or items begins after the deductible is satisfied. The Plan has an embedded deductible. This means once a Covered Person meets the individual deductible, the Plan begins paying benefits for that person. If two or more members of the family meet the family deductible, the Plan begins paying benefits for all members of the family, regardless of whether each Covered Person has met the individual deductible. However, a Covered Person may not contribute more than the individual deductible towards the family deductible. The amount of the charges that apply to the deductible are based on (1) the agreed fee applicable to the Network Provider, or a reasonable estimate of the cost according to a fee schedule equivalent; or (2) the lesser of the billed charge and the Plan's maximum amount allowed for the Non-Network Provider. This Benefits Chart indicates which covered services are not subject to the deductible.

Individual Calendar Year Maximum Benefit: The specified coverage limit paid for all charges combined and actually paid by the Plan for a Covered Person under that coverage. The Plan's payment ceases for that Covered Person when that limit is reached. The Covered Person has to pay for subsequent charges in that year. The charges incurred for Orthodontic Services do not apply to the Individual Calendar Year Maximum Benefit.

Benefits shown below for certain providers apply only when you have selected those providers.

Deductibles, limits and maximums shown below are combined under your Network Benefits and Non-Network Benefits.

Individual Calendar Year Deductible

Network Benefits	**Non-Network Benefits**
Benefit Level 1:	$50
None.	
Benefit Level 2:	
$25	

Family Calendar Year Deductible

Network Benefits	Non-Network Benefits
Benefit Level 1: None. **Benefit Level 2:** $75	$150

Individual Calendar Year Maximum Benefit

Network Benefits	Non-Network Benefits
Benefit Level 1: $2,000 **Benefit Level 2:** $1,500	$1,000

PREVENTIVE AND DIAGNOSTIC SERVICES

Covered Services:

The Plan covers the following preventive and diagnostic services, with certain limitations which are listed below. The Plan covers the following preventive and diagnostic services, with certain limitations which are listed below.
For this category, deductible does not apply.

Routine dental care examinations for new and existing patients

Network Benefits	Non-Network Benefits
Benefit Level 1: 100% of the charges incurred. **Benefit Level 2:** 100% of the charges incurred, limited to twice each calendar year.	80% of the charges incurred, limited to twice each calendar year.

Dental cleaning (prophylaxis or periodontal maintenance cleaning)

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 100% of the charges incurred. **Benefit Level 2:** 100% of the charges incurred, limited to twice each calendar year.	80% of the charges incurred, limited to twice each calendar year.

Professionally applied topical fluoride (other than silver diamine fluoride)

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 100% of the charges incurred. **Benefit Level 2:** 100% of the charges incurred, limited to once each calendar year for Covered Persons under age 19.	80% of the charges incurred, limited to once each calendar year for Covered Persons under age 19.

Silver diamine fluoride

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 100% of the charges incurred. **Benefit Level 2:** 100% of the charges incurred, limited to twice per tooth each calendar year.	80% of the charges incurred, limited to twice per tooth each calendar year.

Pit and Fissure sealant application and preventive resin restoration

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 100% of the charges incurred. **Benefit Level 2:** 100% of the charges incurred, limited to one application per tooth per three-year period, for permanent molars.	80% of the charges incurred, limited to one application per tooth per three year period, for permanent molars.

Bitewing x-rays

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 100% of the charges incurred. **Benefit Level 2:** 100% of the charges incurred, limited to once each calendar year.	80% of the charges incurred, limited to once each calendar year.

Full mouth or panoramic x-rays

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 100% of the charges incurred. **Benefit Level 2:** 100% of the charges incurred, limited to once every three years.	80% of the charges incurred, limited to once every three years.

Other x-rays, except as provided in connection with orthodontic diagnostic procedures and treatment

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 100% of the charges incurred. **Benefit Level 2:** 100% of the charges incurred.	80% of the charges incurred.

Space maintainers for lost primary teeth (fixed or removable appliances designed to prevent adjacent and opposing teeth from moving)

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 100% of the charges incurred for Covered Persons under age 19. **Benefit Level 2:** 100% of the charges incurred, for Covered Persons under age 19.	80% of the charges incurred, for Covered Persons under age 19.

Oral hygiene instruction

Network Benefits	Non-Network Benefits
Benefit Level 1: 100% of the charges incurred. **Benefit Level 2:** 100% of the charges incurred, limited to once per lifetime as an independent procedure.	80% of the charges incurred, limited to once per lifetime as an independent procedure.

Evaluations that are not routine and periodic, including: problem-focused evaluations (either limited or detailed and extensive), periodontal evaluations, and evaluations for Covered Persons under the age of 3 which include counseling with the primary caregiver.

Network Benefits	Non-Network Benefits
Benefit Level 1: 100% of the charges incurred. **Benefit Level 2:** 100% of the charges incurred.	80% of the charges incurred.

Screening or assessments of a patient.

Network Benefits	Non-Network Benefits
Benefit Level 1: 100% of the charges incurred. **Benefit Level 2:** 100% of the charges incurred, limited to twice each calendar year.	80% of the charges incurred, limited to twice each calendar year.

Not Covered:

- Services for the replacement of space maintainers.
- Diagnostic testing that is performed and billed as a separate procedure such as collection of microorganisms for culture, viral cultures, genetic testing for susceptibility or oral disease and caries susceptibility tests. This includes all oral pathology and laboratory testing charges.
- Additional charges for office visits that occur after regularly scheduled hours, office visits for observation, missed appointments or appointments cancelled on short notice.
- Maxillofacial MRI, maxillofacial ultrasound and sialoendoscopy capture and interpretation.
- Post processing of image or image sets.
- Caries risk assessment and documentation.
- Charges for unspecified procedures.
- See “Services Not Covered” in the SPD.

BASIC SERVICES

Covered Services:

The Plan covers the following services:

Basic I Services

Consultations

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 100% of the charges incurred. **Benefit Level 2:** 80% of the charges incurred.	60% of the charges incurred.

Emergency treatment for relief of pain

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 100% of the charges incurred. **Benefit Level 2:** 80% of the charges incurred.	60% of the charges incurred.

Regular restorative services (fillings) other than posterior composites. Restorations using customary restorative materials and stainless steel crowns are covered, when dentally necessary due to loss of tooth structure as a result of tooth decay or fracture.

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 100% of the charges incurred. **Benefit Level 2:** 80% of the charges incurred.	60% of the charges incurred.

Regular restorative services (fillings) - posterior composites (white fillings on bicuspids and molars). Restorations using customary restorative materials are covered, when dentally necessary due to loss of tooth structure as a result of tooth decay or fracture.

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 100% of the charge which is appropriate for an equivalent amalgam/silver filling restoration. **Benefit Level 2:** 80% of the charge which is appropriate for an equivalent amalgam/silver filling restoration.	60% of the charge which is appropriate for an equivalent amalgam/silver filling restoration.

Oral Surgery - non-surgical extraction for the restoration of dental function. General anesthesia or intravenous sedation are covered, when dentally necessary, when provided by the attending dentist in a dental office setting and required to perform a covered dental procedure.

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 80% of the charges incurred. **Benefit Level 2:** 80% of the charges incurred.	50% of the charges incurred.

Periodontics (Gum Disease) - non-surgical treatment

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 80% of the charges incurred. **Benefit Level 2:** 80% of the charges incurred, limited to once in two years for non-surgical treatment.	50% of the charges incurred, limited to once in two years for non-surgical treatment.

Endodontics (Root Canal Therapy)

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 80% of the charges incurred. **Benefit Level 2:** 80% of the charges incurred.	50% of the charges incurred.

Basic II Services

Oral Surgery - other than non-surgical extraction, for the restoration of dental function. General anesthesia or intravenous sedation are covered, when dentally necessary, when provided by the attending dentist in a dental office setting and required to perform a covered dental procedure

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 80% of the charges incurred. **Benefit Level 2:** 80% of the charges incurred.	50% of the charges incurred.

Cone beam CT capture and interpretation, when used for dental implants or extraction of impacted third molars and authorized by a HealthPartners dental director, or his or her designee

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 80% of the charges incurred. **Benefit Level 2:** 80% of the charges incurred.	No Coverage.

Periodontics (Gum Disease) - surgical treatment

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 80% of the charges incurred. **Benefit Level 2:** 80% of the charges incurred, limited to once in two years for surgical treatment.	50% of the charges incurred, limited to once in two years for surgical treatment.

Not Covered:

- Periodontal splinting.
- Orthognathic surgery (surgery to reposition the jaws).
- Procedures, appliances or restorations for the prevention of bruxism (grinding of teeth) or clenching.
- Additional charges for the harvest of bone for use in autogenous grafting procedure.
- Charges for surgical procedures for isolation of a tooth with a rubber dam.
- Charges for the placement of a restorative foundation for an indirect restoration.
- Charges for periradicular services and bone grafts or other material used in conjunction with periradicular surgery.
- Charges for unspecified procedures.
- Cone beam CT capture and interpretation, except when authorized by a HealthPartners dental director or his or her designee. The Plan does not cover cone beam CT interpretation if billed separately. The Plan also does not cover cone beam capture and interpretation for TMJ series.
- See “Services Not Covered” in the SPD.

SPECIAL SERVICES

Covered Services:

The Plan covers the following services:

Special Restorative Care – extraorally fabricated or cast restorations (crowns, onlays) are covered when teeth cannot be restored with customary restorative material and when dentally necessary due to the loss of tooth structure as a result of tooth decay or fracture. If a tooth can be restored with a customary restorative material, but an onlay, crown, jacket, indirect composite or porcelain/ceramic restoration is selected, benefits will be calculated using the charge appropriate to the equivalent customary restorative material.

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 50% of the charges incurred. **Benefit Level 2:** 50% of the charges incurred.	50% of the charges incurred.

Repair or recementing of crowns, inlays and onlays

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 50% of the charges incurred. **Benefit Level 2:** 50% of the charges incurred.	50% of the charges incurred.

Not Covered:

- Onlays, veneers or partial crowns fabricated from extraorally cured composite resin or porcelain.
- Charges for unspecified procedures.
- See “Services Not Covered” in the SPD.

PROSTHETIC SERVICES

Covered Services:

The Plan covers the following services:

Bridges - initial installation of fixed bridgework to replace missing natural teeth, replacement of an existing fixed bridgework by a new bridgework, the addition of teeth to an existing bridgework, and repair or recementing of bridgework are covered. A given prosthetic appliance for the purpose of replacing an existing appliance will be provided when satisfactory evidence is presented that the new prosthetic appliance is required to replace one or more teeth extracted after the existing bridgework was installed.

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 50% of the charges incurred. **Benefit Level 2:** 50% of the charges incurred.	50% of the charges incurred.

Dentures - initial installation of full removable dentures to replace missing natural teeth and adjacent structures and adjustments during the six-month period following installation are covered. If a satisfactory result can be achieved through the utilization of standard procedures and materials but a personalized appliance is selected, or one which involves specialized techniques, the charges appropriate to the least costly appliance are covered. Replacement of an existing full removable denture by a new denture is covered. A given prosthetic appliance for the purpose of replacing an existing appliance will be provided when satisfactory evidence is presented that the new prosthetic appliance is required to replace one or more teeth extracted after the existing denture was installed. Repair of dentures, or relining or rebasing of dentures more than six months after installation of an initial or replacement denture are covered.

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 50% of the charges incurred. **Benefit Level 2:** 50% of the charges incurred.	50% of the charges incurred.

Partial Dentures - Surveyed crowns which are not restorative but which are dentally necessary to facilitate the placement of a removable partial denture are covered. Initial installation of partial removable dentures to replace missing natural teeth and adjacent structures and adjustments during the six-month period following installation are covered. If a satisfactory result can be achieved by a standard cast chrome or acrylic partial denture, but a more complicated design is selected, the charges appropriate to the least costly appliance are covered. Replacement of an existing partial denture by a new denture, or the addition of teeth to an existing partial removable denture is covered. A given prosthetic appliance for the purpose of replacing an existing appliance will be provided when satisfactory evidence is presented that the new prosthetic appliance is required to replace one or more teeth extracted after the existing denture was installed. Repair of dentures, or relining or rebasing of dentures more than six months after installation of an initial or replacement denture are covered.

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 50% of the charges incurred. **Benefit Level 2:** 50% of the charges incurred.	50% of the charges incurred.

Limitations:

- Benefit for replacement of a prosthetic appliance will be provided only (a) if the existing appliance cannot be made serviceable, and (b) after a five year period measured from the date on which it was installed, whether under the Plan or not.

Not Covered:

- Services for replacement of any missing, lost or stolen dental or implant-supported prosthesis.
- Services related to a prosthetic appliance which was installed or delivered more than 60 days after termination of coverage.
- Charges for unspecified procedures.
- See “Services Not Covered” in the SPD.

DENTAL IMPLANT SERVICES

Covered Services:

The Plan covers:

- the surgical placement of an implant body to replace missing natural teeth;
- removal and replacement of an implant body that is not serviceable and cannot be repaired after a period of at least five years from the date that the implant body was initially placed;
- initial installation of implant-supported prosthesis (crowns, bridgework and dentures) to replace missing teeth;
- replacement of an existing implant-supported prosthesis by a new implant-supported prosthesis, or the addition of teeth to an existing implant-supported prosthesis. An existing implant-supported prosthesis will be replaced when satisfactory evidence is presented that (a) the new implant-supported prosthesis is required to replace one or more teeth extracted after the existing implant-supported prosthesis was installed, or (b) the existing implant-supported prosthesis cannot be made serviceable;
- repair of implant-supported prosthesis;
- other related implant services.

Network Benefits	**Non-Network Benefits**
Benefit Level 1: 50% of the charges incurred. **Benefit Level 2:** 50% of the charges incurred.	50% of the charges incurred.

Limitations:

- Benefit for replacement of an existing implant-supported prosthesis that cannot be made serviceable will be provided only after a five year period measured from the date that the implant-supported prosthesis was initially placed, whether under the Plan or not.

Not Covered:

- Charges for unspecified procedures.
- See “Services Not Covered” in the SPD.

EMERGENCY DENTAL CARE SERVICES

Covered Services:

The Plan covers emergency dental care provided by Network Providers or Non-Network Providers to the same extent as eligible dental services specified above and subject to the same deductibles, copayment percentages and maximums.

Network Benefits	**Non-Network Benefits**
Coverage level is the same as corresponding Network Benefits, depending on the type of service provided, such as fillings.	Coverage level is the same as corresponding Non-Network Benefits, depending on the type of service provided, such as fillings.

Not Covered:

- See “Services Not Covered” in the SPD.

ORTHODONTIC SERVICES

Covered Services:

The Plan covers treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies to the age limit and orthodontic maximum shown below. Each limited, interceptive or comprehensive orthodontic treatment includes:

- treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies, to the age limit and orthodontic maximum shown below;
- initial post-treatment retainers.

The Plan pays up to the orthodontic maximum, less the total amount of any benefit received for orthodontic treatment under any prior dental coverage provided by the Plan Sponsor. It is the Covered Person's responsibility to provide documentation of benefits received under prior coverage. Benefits will be paid over the course of orthodontic treatment.
For this category, deductible does not apply.

Network Benefits	**Non-Network Benefits**
Benefit Level 1: For all Covered Persons - 50% of the charges incurred. **Benefit Level 2:** For dependent children under age 19 - 50% of the charges incurred.	No Coverage.

Lifetime Maximum

Network Benefits	**Non-Network Benefits**
Benefit Level 1: $1,500 **Benefit Level 2:** $1,500	None.

Not Covered:

- Charges for fixed or removable appliances to control harmful habits such as tongue thrusting or thumb sucking.
- Charges for unspecified procedures.
- See “Services Not Covered” in the SPD.