

Evidence of Coverage Rider for Enrollees who are enrolled in the Freedom Comprehensive Dental Benefit

Please keep this notice as it is part of your HealthPartners® Freedom Vital with Rx (Cost)/HealthPartners® Freedom Vital (Cost) Evidence of Coverage.

A health plan with a Medicare contract.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2013.

Your Evidence of Coverage is amended as follows:

1. Section 2.2 of Chapter 4, “*Medical Benefits Chart (what is covered and what you pay)*,” of your Evidence of Coverage is replaced by the following:

Section 2.2 Extra “optional supplemental” benefits you can buy

Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package as a plan member. These extra benefits are called “**Optional Supplemental Benefits.**” If you want these optional supplemental benefits, you must sign up for them and you may have to pay an additional premium for them. The optional supplemental benefits included in this section are subject to the same appeals process as any other benefits.

Election and Termination of Freedom Comprehensive Dental Benefit (referred to as “comprehensive dental benefits” below)

As a member of our plan, you have the option of purchasing comprehensive dental benefits. You may select these benefits upon your initial enrollment into the plan, or during the Annual Enrollment Period which occurs from October 15 through December 7 in 2011. For new members, coverage will be effective on the date your HealthPartners Freedom Vital with Rx /HealthPartners Freedom Vital coverage is effective. For existing members, coverage will be effective on the January 1 following the date of your request. Your comprehensive dental benefits will continue if you move to another HealthPartners Freedom plan that offers this benefit, unless you choose to end the benefit, as described below.

The monthly premium in 2012 is \$38.37. This is in addition to your premium for Medicare Part A and/or Medicare Part B, if applicable, and your HealthPartners Freedom Vital with Rx /HealthPartners Freedom Vital monthly premium. The deductible and coinsurance for these covered dental services do not apply to the out-of-pocket limit for covered health care services each year described earlier in this Chapter 4.

You may end your comprehensive dental benefits by giving us written notice of intent to end. Written notice must be sent to:

HealthPartners
Attn.: Membership Accounting Department
8170 33rd Avenue South
P.O. Box 9463
Minneapolis, MN 55440-9463

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Your coverage for comprehensive dental benefits will end on the last day of the month following our receipt of your request to end coverage, or the date you request that your coverage ends, if later. If you pay premiums on a quarterly basis and you request that your coverage for comprehensive dental benefits ends before the end of that quarter, your premiums will be refunded for any unused months of that quarter.

If you end coverage for comprehensive dental benefits and later wish to re-enroll these benefits, you may not re-enroll for the benefits until the next Annual Election Period.

Dental Providers

Dental benefits for covered services may be obtained from our network of participating providers and facilities. A network provider is any one of the participating licensed dentists or other dental care providers or facilities which has entered into an agreement with HealthPartners to provide dental care services to members. This coverage is referred to as “HealthPartners Dental Benefits.” For a listing of participating providers and clinics and their locations, you may call Member Services or check our website at www.healthpartners.com/medicare. You must verify that your dental provider participates with the HealthPartners network each time you receive services.

To obtain HealthPartners Dental Benefits for covered services, you must receive services from HealthPartners network dental providers and facilities. Under limited circumstances, HealthPartners may authorize, at its discretion, the care delivered by out-of-network dental providers to be covered as HealthPartners Dental Benefits. You will also be covered for HealthPartners Dental Benefits if you have activated the extended absence benefit as described in this Chapter 4.

There are no referral requirements for services delivered by our network of participating dental providers. Your dentist will coordinate the authorization process for any services which must first be authorized.

Dental benefits for covered services may also be obtained from out-of-network dental providers. These are licensed dentists or other dental care providers or facilities not participating as network providers. This coverage is referred to as “Out-Of-Network Dental Benefits.”

If you receive services from an out-of-network dental provider, in addition to any deductible or coinsurance, you will be responsible for the difference between the billed charge and the usual and customary charge allowed amount. The usual and customary charge is the maximum amount allowed considered in the calculation of payment of charges for certain covered services. It is consistent with the charge of other providers of a given service or item in the same region.

Covered Services

To be covered, a service must be:

- Dentally necessary;
- Provided while a member is enrolled for these optional supplemental comprehensive dental benefits;
- Not excluded under this EOC.

“Dentally necessary” means care which is limited to diagnostic examination, treatment, and the use of dental equipment and appliances and which is required to prevent deterioration of dental health, or to restore dental function. The member's general health condition must permit the necessary procedure(s).

Our dental director, or his or her designee, makes coverage determinations of dental necessity, restrictions on access and appropriateness of treatment, and makes final authorization for covered services. Frequency limits, deductibles, copayments or 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 our dental director.

Dental Benefits Chart

This section states the amount you pay for covered services listed in the Dental Benefits Chart. For certain services, you must first satisfy an Individual Calendar Year Deductible, as shown below. Benefits are also subject to a Calendar Year Maximum Benefit, except as shown below.

	<u>HealthPartners Dental Benefits</u>	<u>Out-Of-Network Dental Benefits</u>
Individual Calendar Year Deductible	\$50	\$50
	<i>Deductibles under the HealthPartners Dental Benefits and Out-Of-Network Dental Benefits are combined.</i>	
Calendar Year Maximum Benefit	\$1,100, reduced by any Out-Of-Network Dental Benefits.	\$200, subject to a maximum calendar year benefit of \$1,100 for HealthPartners Dental Benefits and Out-Of-Network Dental Benefits combined.

Services that are covered for you	What you must pay when you get these services
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A. PREVENTIVE AND DIAGNOSTIC SERVICES

For this category, the Individual Calendar Year Deductible does not apply

Routine dental care examinations for new and existing patients. Limited to two each calendar year.	Nothing.
Dental cleaning (prophylaxis or periodontal maintenance cleaning). Limited to two each calendar year.	Nothing.
Topical fluoride. Once each calendar year.	Nothing.
Pit and Fissure Sealants and preventive resin restorations. One application per tooth per three-year period, for permanent molars.	50% coinsurance.
Bitewing x-rays and dental x-rays as are required in connection with the diagnosis of a specific condition requiring treatment, except x-rays provided in connection with orthodontic diagnostic procedures and treatment. Limited to once each calendar year.	Nothing.
Limited, problem-focused, including emergency, and periodontal evaluations.	Nothing.

B. BASIC SERVICES

Basic I Services

Emergency treatment for relief of pain.	50% coinsurance.
Regular restorative services (fillings) – restorations using customary restorative materials and stainless steel crowns, when dentally necessary due to loss of tooth structure as a result of tooth decay or fracture.	50% coinsurance.
Oral surgery (non-surgical extraction) for the restoration of dental function, when dentally necessary, provided by the attending dentist in a dental office setting and required to perform a covered dental procedure.	50% coinsurance.
Periodontics (gum disease) – non-surgical treatment. Once in two years.	50% coinsurance.
Endodontics (root canal therapy).	50% coinsurance.

Services that are covered for you	What you must pay when you get these services
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Basic II Services

Oral Surgery (other than non-surgical extraction) for the restoration of dental function including general anesthesia or intravenous sedation, when dentally necessary, provided by the attending dentist in a dental office setting and required to perform a covered dental procedure	50% coinsurance.
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Periodontics (gum disease) – surgical treatment. Once in two years.	50% coinsurance.
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C. SPECIAL SERVICES

Special restorative care – extraorally fabricated or cast restorations (crowns, onlays) when teeth cannot be restored with a 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.	50% coinsurance.
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Repair or recementing of crowns, inlays and onlays. Benefit for the replacement of a crown or onlay will be provided only after a 5 year period measured from the date on which the procedure was last provided, whether under this EOC or not.	50% coinsurance.
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D. PROSTHETIC SERVICES

Initial installation of fixed bridgework to replace missing natural teeth.	50% coinsurance.
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Surveyed crowns which are not restorative but which are dentally necessary to facilitate the placement of a removable partial denture.	50% coinsurance.
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Services that are covered for you	What you must pay when you get these services
<p>Initial installation of partial or full removable dentures to replace missing natural teeth and adjacent structures and adjustments during the six-month period following installation. 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. For full dentures, 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.</p>	50% coinsurance.
<p>Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework. A given prosthetic appliance for the purpose of replacing an existing appliance will be provided when satisfactory evidence is presented that (a) the new prosthetic appliance is required to replace one or more teeth extracted after the existing denture or bridgework was installed, or (b) the existing prosthetic appliance cannot be made serviceable and it was installed at least five years prior to its replacement, whether under these comprehensive dental benefits or not.</p>	50% coinsurance.
<p>Repair or recementing of bridgework or dentures, or relining or rebasing of dentures more than six months after installation of an initial or replacement denture.</p>	50% coinsurance.

E. DENTAL IMPLANT SERVICES

Dental implant services are subject to a \$500 Dental Implant Services calendar year maximum. Any benefits that apply toward the Dental Implant Services calendar year maximum also apply toward the overall Calendar Year Maximum Benefit shown above.

<p>The surgical placement of an implant body to replace missing natural teeth.</p>	50% coinsurance.
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Services that are covered for you	What you must pay when you get these services
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.	50% coinsurance.
Initial installation of implant-supported prosthesis (crowns, bridgework and dentures) to replace missing teeth.	50% coinsurance.
Replacement of an existing implant-supported prosthesis by a new implant-supported prosthesis, or the addition of teeth to an existing implant-supported prosthesis. We will replace an existing implant-supported prosthesis 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 and it was installed at least five years prior to its replacement, whether under these comprehensive dental benefits or not.	50% coinsurance.
Repair of implant-supported prosthesis.	50% coinsurance.

Exclusions

1. Treatment, procedures or services which are not dentally necessary and/or which are primarily educational in nature or for the vocation, comfort, convenience, appearance or recreation of the member.
2. The treatment of conditions which foreseeably result from excluded services.
3. For HealthPartners Dental Benefits, treatment, procedures or services which are not provided, or authorized by a HealthPartners network dentist or other authorized provider or are not authorized by us.
4. Dental services or supplies which are performed primarily for cosmetic purposes or for the purpose of improving the appearance of your teeth. This includes tooth whitening, tooth bonding and veneers that cover the teeth.
5. Hospitalization or other facility charges.
6. Local anesthesia or use of electronic analgesia billed as a separate procedure is not covered. Nitrous oxide is not covered. General anesthesia and intravenous sedation are not covered except as indicated in the Dental Benefits Chart for optional supplemental comprehensive dental benefits.
7. Orthodontic services.
8. Services related to any orthodontic treatment in progress prior to the member's effective date (unless specifically waived).
9. Orthognathic surgery (surgery to reposition the jaws).
10. Services which are elective, investigative, experimental or not otherwise clinically accepted.

11. Procedures, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, or erosion or realigning teeth. Mandibular orthopedic appliances and bite planes are also not covered.
 12. Services for the following items:
 - (a) replacement of any missing, lost or stolen dental or implant-supported prosthesis.
 - (b) replacement or repair of orthodontic appliances.
 - (c) replacement of orthodontic appliances due to non-compliance.
 - (d) replacement of space maintainers.
 13. Services related to a prosthetic or special restorative appliance which was installed or delivered more than 60 days after termination of coverage.
 14. 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.
 15. Dental services, supplies and devices not expressly covered as a benefit under the optional supplemental comprehensive dental benefits.
 16. Prescription drugs and medications prescribed by a dentist.
 17. Services provided to the member which the member is not required to pay.
 18. The portion of a billed charge for an otherwise covered service by an out-of-network provider, which is in excess of the usual and customary charge. We also do not cover charges or a portion of a charge which is either a duplicate charge for a service or charges for a duplicate service.
 19. Services for injury or illness either (a) arising out of an injury in the course of employment and subject to workers' compensation or similar law; or (b) for which benefits are payable without regard to fault, under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance; or (c) for which benefits are payable under another policy of accident and health insurance, or any other governmental program.
 20. Except where expressly addressed under the optional supplemental comprehensive dental benefits, when multiple, acceptable treatment options exist related to a specific dental problem, we will provide benefits based upon the least costly alternative treatment.
 21. Services or supplies to treat any dental disease, defect or injury that is due to an act of war, declared or undeclared.
 22. Services covered under the patient's medical plan, except to the extent not covered under the patient's medical plan.
 23. Additional charges for office visits that occur after regularly scheduled hours, missed appointments or appointments cancelled on short notice.
 24. Onlays, veneers or partial crowns fabricated from extraorally cured composite resin or porcelain.
 25. Periodontal splinting.
 26. Athletic mouthguards.
 27. Charges for infection control, sterilization and waste disposal.
 28. Consultations.
 29. Charges for sales tax.
 30. Services or supplies provided outside of the United States, except for emergency care.
 31. Treatment, procedures, or services or drugs which are provided when you are not covered under this comprehensive benefit.
 32. Cone beam x-rays.
 33. Additional charges for the harvest of bone for use in autogenous grafting procedure.
2. The existing Chapter 4, Section 2.2 "*Getting care using our plan's optional extended absence benefit*" of your Evidence of Coverage is renumbered "Section 2.3".