

# Pediatric Dental Amendment to Your Group Certificate

## Keep this Amendment with your Group Certificate

This Amendment applies to individuals under age 19 who are enrolled in a small employer medical Group Certificate underwritten by HealthPartners Insurance Company. Coverage under this Amendment continues until the end of the month in which the individual turns age 19.

**Effective Date:** The later of the effective date, or most recent anniversary date of the Group Policy and your effective date of coverage under the Group Policy.

**Your Group Certificate (“the Certificate”) is amended as follows:**

**1. In Section ‘INTRODUCTION TO THE GROUP CERTIFICATE,’ “Predetermination of Benefits” is added:**

### **PREDETERMINATION OF BENEFITS**

If a course of treatment is expected to involve charges for dental services in certain categories of care such as Periodontics, Endodontics, Special Services, Prosthetic Services or Orthodontics 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 us 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.

When a predetermination for a service is requested from us, an initial determination must be made within 10 business days, so long as all information reasonably needed to make the decision has been provided.

When a predetermination for an urgent service is requested from us, an initial determination must be made within 72 hours, so long as all information reasonably needed to make a decision has been provided. In the event that the claimant has not provided all information necessary to make a decision, the claimant will be notified of such failure within 24 hours. The claimant will then be given 48 hours to provide the requested information. The claimant will be notified of the benefit determination within 48 hours after the earlier of our receipt of the complete information or the end of the time granted to the claimant to provide the specified additional information.

If the predetermination is made to approve the service, we will notify your dental care provider by telephone, and may send written verification.

If the initial determination is made not to approve the service, we will notify your dental care provider, if appropriate, by telephone within one working day of the determination, and we will send written verification with details of the denial.

If you want to request an expedited review, or have received a denial of a predetermination and want to appeal that decision, you have a right to do so. If your complaint is not resolved to your satisfaction in the internal complaint and appeal process, you may request an external review under certain circumstances. Refer to Section “Disputes and Complaints” for a description of how to proceed.

Call Member Services for more information on predetermination of benefits.

We will notify the dentist of the predetermination, based on the course of treatment. In determining the amount we pay, consideration is given to alternate procedures, services, supplies, or courses of treatment that may be performed for such dental condition. The amount we pay as authorized dental charges is the appropriate amount determined in accordance with the terms of the Certificate.

If a description of the procedures to be performed, and an estimate of the dentist's charges are not submitted in advance, we reserve 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 for services to be performed is limited to services performed within 90 days from the date such course of treatment was approved by us. Additional services required after 90 days may be submitted in writing, as a new course of treatment, and approved on the same basis as the prior plan.

**2. In Section 'DEFINITIONS OF TERMS USED,' the following definitions are added:**

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

**Consultations.** These are diagnostic services provided by a dentist or dental specialist other than the practitioner who is providing treatment.

**Cosmetic Care.** These are dental services to improve appearance, without treatment of a related illness or injury.

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

**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.

**Dentally Necessary.** This is 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 insured's general health condition must permit the necessary procedure(s). Decisions about dental necessity are made by HealthPartners Insurance Company.'s dental directors or their designees.

**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.

**Elective Procedures.** These are procedures which are available to patients but which are not dentally necessary.

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

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

**Medically Necessary Orthodontic Services.** These are comprehensive medically necessary services covered for pediatric dental insureds who have a severe handicapping malocclusion related to a medical condition resulting from congenital, craniofacial or dentofacial malformations involving the teeth and requiring reconstructive surgical correction in addition to orthodontic services.

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

**Orthodontics.** This is medically necessary dental care for the correction of severe handicapping malocclusion of teeth using appliances and techniques that alter the position of teeth in the jaws.

**Orthognathic Surgery.** This is oral surgery to alter the position of the jaw bones.

**Periodontics.** This is non-surgical and surgical treatment of diseases of the gingiva (gums) and bone supporting the teeth.

**Prosthetic Services.** These are services to replace missing teeth; including the prescribing, repair, construction, replacement and fitting of fixed bridges and full or partial removable dentures.

**3. The following are added to Section “SERVICES NOT COVERED,” and apply only to Pediatric Dental benefits:**

- 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 insured.
- The treatment of conditions which foreseeable result from excluded services.
- For Network Benefits, treatment, procedures or services which are not provided by a network dentist or other authorized provider or are not authorized by us.
- 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. This exclusion does not apply to services for reconstructive surgery. However, to the extent that these reconstructive surgery services are paid as medical services under the Certificate, they are not covered as Pediatric Dental services.
- Hospitalization or other facility charges.
- Local anesthesia or use of electronic analgesia billed as a separate procedure is not covered. Inhaled nitrous oxide is not covered. General anesthesia and intravenous sedation are not covered except as indicated in this Amendment.
- Orthodontic services, except as provided in this Amendment.
- Orthognathic surgery (surgery to reposition the jaws).
- Services which are elective, investigative, experimental or not otherwise clinically accepted.
- 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 (including chipping or fractures), or erosion or realigning teeth, except as covered orthodontic services provided in this Amendment. Mandibular orthopedic appliances and bite planes are also not covered.
- Procedures, appliances (other than occlusal guards, as indicated in this Amendment) or restorations for the prevention of bruxism (grinding of teeth) or clenching.
- Services for the following items:
  - replacement of any missing, lost or stolen dental or implant-supported prosthesis.
  - replacement or repair of orthodontic appliances.
  - replacement of orthodontic appliances due to non-compliance.
- Services related to a prosthetic or special restorative appliance which was installed or delivered more than 60 days after termination of coverage.
- 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.
- For non-network coverage, dental services related to the replacement of any teeth missing prior to the insured’s effective date under this Amendment.
- Dental services, supplies and devices not expressly covered as a benefit under this Amendment.
- Prescription drugs and medications prescribed by a dentist. This includes gingival irrigation.
- Services provided to the insured which the insured is not required to pay.
- The portion of a billed charge for an otherwise covered service by a non-network provider, which is in excess of our maximum amount allowed. 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.
- Services for injury or illness either (a) arising out of an injury in the course of employment and subject to workers’ compensation or similar law; or (b) for which benefits are payable without regard to fault, under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance; or (c) for which benefits are payable under another policy of accident and health insurance, Medicare or any other governmental program.
- Except where expressly addressed in this Amendment, when multiple, acceptable treatment options exist related to a specific dental problem, we will provide benefits based upon the least costly alternative treatment. This includes inlay restorations paid as corresponding amalgam restorations.
- Services covered under the patient’s medical plan, except to the extent not covered under the patient’s medical plan.

- Additional charges for office visits that occur after regularly scheduled hours, missed appointments or appointments cancelled on short notice.
- Onlays, veneers or partial crowns fabricated from extraorally cured composite resin or porcelain.
- Periodontal splinting.
- Athletic mouthguards.
- Charges for infection control, sterilization and waste disposal.
- Charges for sales tax.
- Treatment, procedures, or services or drugs which are provided when you are not covered under this Amendment.
- Cone beam CT capture and interpretation.
- Harvest of bone for use in autogenous grafting procedure.
- Charges for maxillofacial prosthetics.
- Charges for case presentations for treatment planning or behavioral management.
- Charges for enamel microabrasion, odontoplasty and pulpal regeneration.
- Charges for surgical procedures for isolation of a tooth with a rubber dam.
- Non-intravenous conscious sedation and drugs to treat anxiety or pain.
- Charges for endodontic endosseous implants.
- Charges for intentional reimplantation (including necessary splinting).
- Charges for canal preparation and fitting of preformed dowel or post.
- Charges for temporary crowns for fractured teeth.
- Charges for interim or custom abutments for implants.
- Charges for rebonding, recementing and repair of fixed retainers.
- Charges for surgical placement of a temporary anchorage device.
- Charges for autogenous or nonautogenous osseous, osteoperiosteal or cartilage graft of the mandible or maxilla.
- Charges for anatomical crown exposure.
- Interim prostheses.
- Connector bars, stress breakers and precision attachments.
- Provisional pontics, crowns and retainer crowns.
- Copings.
- Oral hygiene instruction.
- Removal of fixed space maintainers.
- Hospital, home and extended care facility visits by dental providers.
- Gold foil restorations.
- Treatment for correction of malocclusion of teeth and associated dental and facial disharmonies, and post-treatment retainers, when treatment is not medically necessary.
- 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.
- 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.
- Non-dental administrative fees and charges including, but not limited to dental record preparation, and interest charges.
- Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD).

**4. The Benefits Chart is expanded to include the following:**

### **Pediatric Dental Benefits Chart**

**The Certificate covers Preventive and Diagnostic Services, Basic, Special, Prosthetic and medically necessary Orthodontia Services only, for insureds under age 19.**

**HealthPartners Insurance Company 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 medically or dentally necessary. The date of service must be while you are enrolled in the plan.**

**Coverage for eligible services is subject to the exclusions, limitations and other conditions of this Amendment.**

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

**The amount that we pay for covered services is listed below. The insured is responsible for the specified dollar amount and/or percentage of charges that we do not pay. Coverage may vary according to your network selection.**

**Benefits are underwritten by HealthPartners Insurance Company.**

**When you use Non-Network providers, benefits are substantially reduced and you will likely incur significantly higher out-of-pocket expenses. A Non-Network provider does not usually have an agreement with HealthPartners Insurance Company to provide services at a discounted fee. In addition, Non-Network Benefits are restricted to the usual and customary amount under the definition of "Charge". The usual and customary amount can be significantly lower than a Non-Network provider's billed charges. If the Non-Network provider's billed charges are over the usual and customary amount, you pay the difference, in addition to any required deductible, copayment and/or coinsurance, and these charges do not apply to the out-of-pocket limit.**

**This plan is subject to plan and benefit changes required to maintain compliance with federal and state law. This includes, but is not limited to, benefit changes required to maintain a certain actuarial value or metal level. We may also change your deductible, coinsurance and out-of-pocket limit values on an annual basis to reflect cost of living increases.**

**These definitions apply to this Amendment.**

**Calendar Year:** This is the 12-month period beginning 12:01 A.M. Central Time, on January 1, and ending 12:00 A.M. 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 our maximum amount allowed for that service, procedure or item.

Our maximum amount allowed is based on the usual and customary charge for a given dental/surgical service, procedure or item. 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 insured'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 our maximum amount allowed.

**Copayment/Coinsurance:** The specified dollar amount, or percentage, of charges incurred for covered services, which we do not pay, but which an insured must pay, each time an insured receives certain dental services, procedures or items. Our 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 our 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 we do not pay, but an insured or a family has to pay first in a calendar year. Our payment for those services or items begins after the deductible is satisfied. 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 our maximum amount allowed for the non-network provider. This Benefits Chart indicates which covered services are not subject to the deductible.

**Out-of-Pocket Expenses:** You pay the specified copayments/coinsurance and deductibles applicable for particular services, subject to the out-of-pocket limit described below. These amounts are in addition to the monthly premium payments.

**Out-of-Pocket Limit:** You pay the copayments/coinsurance and deductibles for covered services, to the individual or family out-of-pocket limit. Thereafter we cover 100% of charges incurred for all other covered services, for the rest of the calendar year. You pay amounts greater than the out-of-pocket limits if any benefit maximums are exceeded.

Non-Network Benefits above the maximum amount allowed (see definition of “charge” above) do not apply to the out-of-pocket limit.

You are responsible to keep track of the out-of-pocket expenses. Contact Member Services for assistance in determining the amount paid by the insured for specific eligible services received. Claims for reimbursement under the out-of-pocket limit provisions are subject to the same time limits and provisions described under the "Claims Provisions" section of the Certificate.

**Limits shown below are combined under your Network Benefits and Non-Network Benefits.**

**Individual Calendar Year Deductible (applies to an employee enrolled for single coverage)**

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
See your Network Benefits individual deductible under your Medical Plan Benefits Chart.	See your Non-Network Benefits individual deductible under your Medical Plan Benefits Chart.

**Family Calendar Year Deductible (applies to an employee and dependents enrolled for family coverage)**

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
See your Network Benefits family deductible under your Medical Plan Benefits Chart.	See your Non-Network Benefits family deductible under your Medical Plan Benefits Chart.

**Individual Calendar Year Out-of-Pocket Limit (applies to an employee enrolled for single coverage)**

<b><u>Network Benefits</u></b> See your Network Benefits individual out-of-pocket limit under your Medical Plan Benefits Chart.	<b><u>Non-Network Benefits</u></b> See your Non-Network Benefits individual out-of-pocket limit under your Medical Plan Benefits Chart.
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**Family Calendar Year Out-of-Pocket Limit (applies to an employee and dependents enrolled for family coverage)**

<b><u>Network Benefits</u></b> See your Network Benefits family out-of-pocket limit under your Medical Plan Benefits Chart.	<b><u>Non-Network Benefits</u></b> See your Non-Network Benefits family out-of-pocket limit under your Medical Plan Benefits Chart.
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**PREVENTIVE AND DIAGNOSTIC SERVICES**

**Covered Services:**

We cover the following preventive and diagnostic services, with certain limitations which are listed below. For this category, deductible does not apply to: Network Benefits.

**Routine dental care examinations for new and existing patients**

<b><u>Network Benefits</u></b> 100% of the charges incurred, limited to twice each calendar year.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred, limited to twice each calendar year.
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**Dental cleaning (prophylaxis or periodontal maintenance cleaning)**

<b><u>Network Benefits</u></b> 100% of the charges incurred, limited to twice each calendar year.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred, limited to twice each calendar year.
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**Professionally applied topical fluoride (other than silver diamine fluoride)**

<b><u>Network Benefits</u></b> 100% of the charges incurred, limited to twice each calendar year.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred, limited to twice each calendar year.
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**Silver diamine fluoride**

<b><u>Network Benefits</u></b> 100% of the charges incurred, limited to twice per tooth each calendar year.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred, limited to twice per tooth each calendar year.
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**Pit and Fissure sealant application and preventive resin restoration**

<b><u>Network Benefits</u></b> 100% of the charges incurred, limited to one application per tooth per 36-month period, for unrestored permanent molars.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred, limited to one application per tooth per 36-month period, for unrestored permanent molars.
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**Bitewing x-rays**

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred, limited to twice each calendar year.	50% of the charges incurred, limited to twice each calendar year.

**Full mouth or panoramic x-rays**

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred, limited to once every sixty months.	50% of the charges incurred, limited to once every sixty months.

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

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred.	50% of the charges incurred.

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

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred for lost primary teeth.	50% of the charges incurred for lost primary teeth.

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

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred.	50% of the charges incurred.

**Screening or assessments of a patient**

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred, limited to twice each calendar year.	50% of the charges incurred, limited to twice each calendar year.

**Not Covered:**

- 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.
- Cone beam CT capture and interpretation.
- Oral hygiene instruction.
- Removal of fixed space maintainers.
- Hospital, home and extended care facility visits by dental providers.
- 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 item 3. of this Amendment.



**BASIC SERVICES**

**Covered Services:**

We cover the following services:

**Basic I Services**

**Consultations**

<b><u>Network Benefits</u></b> 100% of the charges incurred.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred.
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**Emergency treatment for relief of pain**

<b><u>Network Benefits</u></b> 100% of the charges incurred.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred.
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**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.**

<b><u>Network Benefits</u></b> 100% of the charges incurred.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred.
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**Regular restorative services (fillings) - posterior composites (white fillings on bicuspids and molars). Restorations using customary restorative materials and preventive resin restorations are covered, when dentally necessary due to loss of tooth structure as a result of tooth decay or fracture.**

<b><u>Network Benefits</u></b> 100% of the charges incurred.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred.
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**Oral Surgery - non-surgical extraction for the restoration of dental function. General anesthesia or intravenous sedation is covered, when dentally necessary, when provided by the attending dentist in a dental office setting and required to perform a covered dental procedure.**

<b><u>Network Benefits</u></b> 100% of the charges incurred.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred.
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**Periodontics (Gum Disease) - non-surgical treatment**

<b><u>Network Benefits</u></b> 100% of the charges incurred, limited to once every 24 months for non-surgical treatment.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred, limited to once every 24 months for non-surgical treatment.
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**Endodontics I - Endodontic Pulp Therapy and Pulpotomy Services (other than pulpal regeneration)**

<b><u>Network Benefits</u></b> 100% of the charges incurred.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred.
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**Endodontics II - All Other Endodontic Services (including pulpal regeneration)**

<b><u>Network Benefits</u></b> 100% of the charges incurred.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred.
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**Basic II Services**

**Oral Surgery** - other than non-surgical extraction for the restoration of dental function. Services include, but are not limited to, removal of impacted teeth, incision or drainage of abscesses and removal of exostosis. General anesthesia or intravenous sedation is covered, when dentally necessary, when provided by the attending dentist in a dental office setting and required to perform a covered dental procedure.

<b><u>Network Benefits</u></b> 100% of the charges incurred.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred.
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**Periodontics (Gum Disease) - surgical treatment**

<b><u>Network Benefits</u></b> 100% of the charges incurred, limited to once every 36 months for surgical treatment.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred, limited to once every 36 months for surgical treatment.
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**Limitations:**

- Collection and application of autologous blood concentrate product is limited to once every 36 months.

**Not Covered:**

- Periodontal splinting.
- Orthognathic surgery (surgery to reposition the jaws).
- Harvest of bone for use in autogenous grafting procedure.
- Charges for surgical procedures for isolation of a tooth with a rubber dam.
- Non-intravenous conscious sedation, and drugs to treat anxiety or pain.
- Charges for endodontic endosseous implants.
- Charges for intentional reimplantation (including necessary splinting).
- Charges for canal preparation and fitting of preformed dowel or post.
- Charges for temporary crowns for fractured teeth.
- Charges for surgical placement of a temporary anchorage device.
- Charges for autogenous or nonautogenous osseous, osteoperiosteal or cartilage graft of the mandible or maxilla.
- Charges for anatomical crown exposure.
- 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.
- See “Services Not Covered” in item 3. of this Amendment.

**SPECIAL SERVICES**

**Covered Services:**

We cover the following services:

**Special Restorative Care** – extraorally fabricated or cast restorations (crowns, inlays and 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.

<b><u>Network Benefits</u></b> 100% of the charges incurred.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred.
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**Repair or recementing of crowns, inlays and onlays**

<b><u>Network Benefits</u></b> 100% of the charges incurred.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred.
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**Limitations:**

- Benefit for the replacement of a crown or onlay will be provided only after a five year period measured from the date on which the procedure was last provided, whether under this Amendment or not.

**Not Covered:**

- Gold foil restorations.
- Onlays, veneers or partial crowns fabricated from extraorally cured composite resin or porcelain
- Charges for unspecified procedures.
- See “Services Not Covered” in item 3. of this Amendment.

**PROSTHETIC SERVICES**

**Covered Services:**

We cover 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.

<b><u>Network Benefits</u></b> 100% of the charges incurred.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred.
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**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.

<b><u>Network Benefits</u></b> 100% of the charges incurred.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred.
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**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.

<b><u>Network Benefits</u></b> 100% of the charges incurred.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred.
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**Occlusal guards** – occlusal guards for the treatment of bruxism are covered, including repair and relining of occlusal guards.

<b><u>Network Benefits</u></b> 100% of the charges incurred.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred.
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**Tissue Conditioning**

<b><u>Network Benefits</u></b> 100% of the charges incurred.	<b><u>Non-Network Benefits</u></b> 50% of the charges incurred.
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**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 5 year period measured from the date on which it was installed, whether under this Amendment or not.
- Occlusal guards are limited to one every 12 months, for insureds age 13 or older.

**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.
- Interim prostheses.
- Connector bars, stress breakers and precision attachments.
- Provisional pontics, crowns and retainer crowns.
- Copings.
- Charges for unspecified procedures.
- See “Services Not Covered” in item 3. of this Amendment.

**DENTAL IMPLANT SERVICES**

**Covered Services:**

We cover, **if dentally necessary:**

- 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. 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;
- repair of implant-supported prosthesis;
- other related implant services.

Decisions about dental necessity are made by HealthPartners Insurance Company’s dental directors, or their designees. If the dental directors or their designees determine that a tooth or an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedure. For the second phase of treatment (the prosthodontics phase of placing the implant crown, bridge, denture or partial denture), we will base benefits on the least costly, professionally acceptable alternative treatment.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% 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 this Amendment or not.
- Endosteal implants, surgical placement of an interim implant body, eposteal implants, transosteal implants (including hardware), implant-supported complete or partial dentures, connecting bars, abutments, implant-supported crowns, and abutment supported retainers are limited to once every 5 years.
- Radiographic/surgical implant indexing is limited to once every 5 years.

**Not Covered:**

- Charges for interim abutments or custom abutments, including placement.
- Charges for unspecified procedures.
- See “Services Not Covered” in item 3. of this Amendment.

**EMERGENCY DENTAL CARE SERVICES**

**Covered Services:**

We cover emergency dental care provided by network or non-network providers to the same extent as eligible dental services specified above and subject to the same deductibles, percentages and maximums.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
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 item 3. of this Amendment.

**CLEFT LIP AND CLEFT PALATE SERVICES**

**Covered Services For Dependent Children:**

We cover dental services for treatment of cleft lip and cleft palate. Orthodontic treatment of cleft lip and cleft palate will be covered only if it meets the Covered Services criteria under “Orthodontic Services” below.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
Coverage level is the same as corresponding Network Benefits, depending on the type of service provided, such as Basic Services, Special Services or Orthodontic Services, if applicable.	Coverage level is the same as corresponding Non-Network Benefits, depending on the type of service provided, such as Basic Services, Special Services or Orthodontic Services, if applicable.

**Limitations:**

- To the extent that these services are covered under the medical services, they are not covered as Pediatric Dental services.

**Not Covered:**

- Charges for unspecified procedures.
- See “Services Not Covered” in item 3. of this Amendment.

**ORTHODONTIC SERVICES**

**Covered Services:**

We cover medically necessary orthodontic services necessary for the correction of severe handicapping malocclusion of teeth. Orthodontia may be considered medically necessary when the treatment is intended to correct a medical condition resulting from congenital, craniofacial or dentofacial malformations involving the teeth and requiring reconstructive surgical correction in addition to orthodontic services. Each orthodontic treatment includes:

- treatment necessary for the correction of severe handicapping malocclusion of teeth;
- initial post-treatment retainers.

Benefits will be paid over the course of orthodontic treatment.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred.	No Coverage.

**Not Covered:**

- Treatment for correction of severe handicapping malocclusion of teeth, and post-treatment retainers, when treatment is not medically necessary.
- Charges for rebonding, recementing and repair of fixed retainers.
- Charges for unspecified procedures.
- See “Services Not Covered” in item 3. of this Amendment.