

HealthPartners Dental Distinctions Appendix

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

See the Membership Contract for additional information about covered services and limitations.

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

The amount that we pay for covered services is listed below. The member is responsible for the specified dollar amount and/or percentage of charges that we do not pay.

HealthPartners Benefits (Level 1 and Level 2) are underwritten by HealthPartners. Non-Network Benefits are underwritten by HealthPartners Insurance Company.

These definitions apply to the Appendix. They also apply to the Contract.

Charge: For covered services delivered by participating network providers, or network referral providers, is the provider's negotiated 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, is the provider's charge for a given dental/surgical service, procedure or item, according to the usual and customary charge allowed amount.

The Usual and Customary Charge is the maximum amount allowed we consider 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 community.

To be covered, a charge must be incurred on or after the member'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 usual and customary charge.

Copayment/Coinsurance: The specified dollar amount, or percentage, of charges incurred for covered services, which we do not pay, but which a member must pay, each time a member 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 Contract. 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 usual and customary charge. 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 a member or a family has to pay first in a calendar year. Our payment for those services or items begins after the deductible is satisfied. If you have a family deductible, each individual family member may only contribute up to the individual deductible amount toward the family deductible. An individual's copayments and coinsurance do not apply toward 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 usual and customary charge for the non-network provider. The Appendix 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 us for a member under that coverage. Our payment ceases for that member, when that limit is reached. The member 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.

	<u>HealthPartners Benefits - Benefit Level 1</u>	<u>HealthPartners Benefits - Benefit Level 2</u>	<u>Non-Network Benefits</u>
	<i>Each service rendered under the same provisions of your HealthPartners Benefits - Benefit Level 2 and Non-Network Benefits counts toward any Deductibles, Limits and Maximums shown under your HealthPartners Benefits - Benefit Level 1.</i>	<i>Each service rendered under the same provisions of your HealthPartners Benefits - Benefit Level 1 and Non-Network Benefits counts toward any Deductibles, Limits and Maximums shown under your HealthPartners Benefits - Benefit Level 2.</i>	<i>Each service rendered under the same provisions of your HealthPartners Benefits - Benefit Level 1 and HealthPartners Benefits - Benefit Level 2 counts toward any Deductibles, Limits and Maximums shown under your Non-Network Benefits.</i>
Individual Calendar Year Deductible	None.	\$10	\$25
Family Calendar Year Deductible	None.	\$30	\$75
Individual Calendar Year Maximum Benefit	\$2,000	\$1,500	\$1,000

COVERED SERVICES	<u>HealthPartners Benefits - Benefit Level 1</u>	<u>HealthPartners Benefits - Benefit Level 2</u>	<u>Non-Network Benefits</u>
A. PREVENTIVE AND DIAGNOSTIC SERVICES For this category, deductible does not apply	Benefits as prescribed by the HealthPartners dentist.		
Examinations	100% of the charges incurred.	100% of the charges incurred. Twice each calendar year.	100% of the charges incurred. Twice each calendar year.
Dental cleaning (prophylaxis)	100% of the charges incurred.	100% of the charges incurred. Twice each calendar year.	100% of the charges incurred. Twice each calendar year.
Topical fluoride	100% of the charges incurred.	100% of the charges incurred. Once each calendar year for members under age 19.	100% of the charges incurred. Once each calendar year for members under age 19.
Pit and fissure sealants	100% of the charges incurred.	100% of the charges incurred. One application per tooth per three-year period, for permanent molars.	100% of the charges incurred. One application per tooth per three year period, for permanent molars.
Bitewing x-rays	100% of the charges incurred.	100% of the charges incurred. Once each calendar year.	100% of the charges incurred. Once each calendar year.
Full mouth or panoramic x-rays	100% of the charges incurred.	100% of the charges incurred. Once every three years.	100% of the charges incurred. Once every three years.
Space maintainers	100% of the charges incurred, for lost primary teeth for dependent members under age 19.	100% of the charges incurred, for lost primary teeth for dependent members under age 19.	100% of the charges incurred, for lost primary teeth for dependent members under age 19.
B. BASIC SERVICES			
<i>Basic I Services</i>			
Consultations	100% of the charges incurred.	100% of the charges incurred.	80% of the charges incurred.
Emergency treatment for relief of pain	100% of the charges incurred.	100% of the charges incurred.	80% of the charges incurred.
Fillings – regular restorative services other than posterior composites	100% of the charges incurred.	100% of the charges incurred.	80% of the charges incurred.
Fillings – posterior composites (white fillings on bicuspid and molars)	100% of the charges incurred.	100% of the charges incurred.	80% of the charges incurred.

COVERED SERVICES	<u>HealthPartners Benefits - Benefit Level 1</u>	<u>HealthPartners Benefits - Benefit Level 2</u>	<u>Non-Network Benefits</u>
Oral surgery – non-surgical extraction	100% of the charges incurred.	100% of the charges incurred.	80% of the charges incurred.
Periodontics(Gum Disease) – non-surgical treatment	100% of the charges incurred.	100% of the charges incurred. Once in two years for surgical or non-surgical treatment.	80% of the charges incurred. Once in two years for surgical or non-surgical treatment.
Endodontics (Root canal therapy)	100% of the charges incurred.	100% of the charges incurred.	80% of the charges incurred.
<i>Basic II Services</i>			
Oral surgery – other than non-surgical extraction	100% of the charges incurred.	100% of the charges incurred.	80% of the charges incurred.
Periodontics (Gum Disease) – surgical treatment	100% of the charges incurred.	100% of the charges incurred. Once in two years for surgical or non-surgical treatment.	80% of the charges incurred. Once in two years for surgical or non-surgical treatment.
C. SPECIAL SERVICES			
Special restorative care	80% of the charges incurred.	80% of the charges incurred.	50% of the charges incurred.
Repair or recementing of crowns, inlays and onlays	80% of the charges incurred.	80% of the charges incurred.	50% of the charges incurred.
D. PROSTHETIC SERVICES			
Bridges	80% of the charges incurred.	80% of the charges incurred.	50% of the charges incurred.
Dentures	80% of the charges incurred.	80% of the charges incurred.	50% of the charges incurred.
Partial Dentures	80% of the charges incurred.	80% of the charges incurred.	50% of the charges incurred.
E. DENTAL IMPLANT SERVICES			
	80% of the charges incurred, subject to the dental implant services calendar year maximum shown below.	80% of the charges incurred, subject to the dental implant services calendar year maximum shown below.	50% of the charges incurred, subject to the dental implant services calendar year maximum shown below.
Dental Implant Services Calendar Year Maximum	\$500	\$500	\$500

The dental implant services calendar year maximum under the HealthPartners Benefits - Benefit Level 1, HealthPartners Benefits - Benefit Level 2 and Non-Network Benefits is combined. Any benefits that apply toward the dental implant services calendar year maximum also apply toward the overall Calendar Year Maximum shown above.

COVERED SERVICES

HealthPartners Benefits - Benefit Level 1

HealthPartners Benefits - Benefit Level 2

Non-Network Benefits

F. EMERGENCY DENTAL CARE SERVICES

Coverage level is the same as corresponding HealthPartners Benefits - Benefit Level 1, depending on the type of service provided, such as fillings.

Coverage level is the same as corresponding HealthPartners Benefits - Benefit Level 2, 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.

G. ORTHODONTIC SERVICES

For this category, deductible does not apply

For all members

50% of the charges incurred.

50% of the charges incurred.

50% of the charges incurred.

Lifetime Maximum

\$2,000

\$1,500

\$1,500

We pay up to the orthodontic maximum, less the total amount of any benefit received for orthodontic treatment under any prior dental coverage provided by the enrollee's group dental plan sponsor. It is the member's responsibility to provide documentation of benefits received under prior coverage.