Amendment to Add Pediatric Dental To HealthPartners Group Membership Contract

Keep this Amendment with your Group Membership Contract

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

Your Group Membership Contract is amended to incorporate the attached Group Membership Contract and Benefits Chart for pediatric dental benefits.

HealthPartners®

Group Membership Contract

HealthPartners Pediatric Dental Plan
For Small Employers

Please save for future reference

CON-403.0 SHPD 1-14

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HealthPartners Pediatric Dental Plan
Group Membership Contract

(Rev. 1-14)

HEALTHPARTNERS MISSION

OUR MISSION IS TO IMPROVE THE HEALTH OF OUR MEMBERS, OUR PATIENTS AND THE COMMUNITY.

ABOUT HEALTHPARTNERS, INC. and HEALTHPARTNERS INSURANCE COMPANY

HealthPartners, Inc. (HealthPartners). HealthPartners is a non-profit corporation which is licensed by the State of Minnesota as a Health Maintenance Organization (HMO). HealthPartners underwrites the HealthPartners Network Dental Benefits described in this Contract. HealthPartners is the parent company of a family of related organizations and provides administrative services for HealthPartners Insurance Company. When used in this Contract, "we," "us" or "our" has the same meaning as "HealthPartners" and its related organizations.

HealthPartners Insurance Company. HealthPartners Insurance Company is the insurance company underwriting the Non-Network Dental Benefits described in this Contract. HealthPartners Insurance Company is a part of the HealthPartners family of related organizations.

The dental coverage described in this Contract may not cover all your dental care expenses. Read this Contract carefully to determine which expenses are covered.

The laws of the State of Minnesota provide members of an HMO certain legal rights, including the following:

IMPORTANT ENROLLEE INFORMATION FOR HEALTHPARTNERS NETWORK DENTAL SERVICES

1. COVERED SERVICES. These are services provided by participating network providers or authorized by those providers. This Contract fully defines what services are covered and describes procedures you must follow to obtain coverage.

2. PROVIDERS. Enrolling with us does not guarantee services by a particular provider on the list of network providers. When a provider is no longer part of the network, you must choose among remaining network providers.

3. EXCLUSIONS. Certain services or dental supplies are not covered. Read this Contract for a detailed explanation of all exclusions.

4. CONTINUATION. You may continue coverage under certain circumstances. Read this Contract for a description of your continuation rights.

5. CANCELLATION. Your coverage may be cancelled by you or us only under certain conditions. Read this Contract for the reasons for cancellation of coverage.

6. NEWBORN COVERAGE. A newborn infant is covered from birth. We will not automatically know of the newborn's birth or that you would like coverage under your plan. You should notify us of the newborn's birth and that you would like coverage. If your contract requires an additional enrollment payment for each dependent, we are entitled to all enrollment payments due from the time of the infant's birth until the time you notify us of the birth. We may withhold payment of any dental benefits for the newborn infant until any enrollment payments you owe are paid.

ENROLLEE BILL OF RIGHTS FOR HEALTHPARTNERS NETWORK DENTAL SERVICES

1. Enrollees have the right to available and accessible services including emergency services 24 hours a day and seven days a week;

2. Enrollees have the right to be informed of health or dental problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice;

3. Enrollees have the right to refuse treatment, and the right to privacy of medical or dental and financial records maintained by the health maintenance organization and its health or dental care providers, in accordance with existing law;

4. Enrollees have the right to file a complaint with the health maintenance organization and the Commissioner of Health and the right to initiate a legal proceeding when experiencing a problem with the health maintenance organization or its health or dental care providers;

5. Enrollees have the right to a grace period of 31 days for each premium payment due, when falling due after the first premium payment, during which period the contract shall continue in force.

TERMS AND CONDITIONS OF USE OF THIS CONTRACT

1. This document may be available in printed and/or electronic form.

2. Only HealthPartners is authorized to amend this document.

3. Any other alteration to a printed or electronic plan document is unauthorized.

4. In the event of a conflict between printed or electronic plan documents, only the authorized plan document will govern.

I. INTRODUCTION TO THE GROUP MEMBERSHIP CONTRACT

A. GROUP MEMBERSHIP CONTRACT

This Group Membership Contract (this Contract) is the enrollee's evidence of coverage under the Master Group Contract issued by HealthPartners and HealthPartners Insurance Company to the enrollees' group dental plan sponsor. The Master Group Contract provides for the dental coverage described in this Contract. It covers the enrollee and the eligible enrolled dependents (if any) as named on the enrollee's membership application. This Contract replaces any prior dental membership contract issued by us. The enrollee and his or her enrolled dependents are members of HealthPartners.

B. IDENTIFICATION CARD

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

C. ASSIGNMENT OF BENEFITS

You may not assign or in any way transfer your rights under this Contract.

D. ENROLLMENT PAYMENTS

This Contract is conditioned on our regular receipt of enrollees' enrollment payments. The enrollment payments are made through the enrollee's group dental plan sponsor, unless we have agreed to another payment method. Enrollment payments are based upon the contract type and the number and status of eligible enrolled dependents enrolled with the enrollee.

Please refer to the most recent enrollment material for information regarding contributions to your plan which is hereby incorporated by this reference.

E. BENEFITS

This Contract provides **HealthPartners Network Dental Benefits** (HealthPartners Benefits) underwritten and administered by HealthPartners, for dental services delivered by participating HealthPartners Network Dental providers.

This Contract describes your **HealthPartners Benefits** and how to obtain covered services.

This Contract also provides **Non-Network Dental Benefits**, (Non-Network Benefits) underwritten by HealthPartners Insurance Company for dental services delivered by Non-Network providers**.** This coverage is in addition to your network coverage under this Contract.

This Contract describes your **Non-Network Benefits** and how to obtain covered services.

F. BENEFITS CHART

Attached to this Contract is a Benefits Chart, which is incorporated and fully made a part of this Contract. It describes the amounts of payments and limits for the coverage provided under this Contract. Refer to your Benefits Chart for the amount of coverage applicable to a particular benefit.

G. CHANGES IN BENEFITS

We are permitted to change benefits under this Contract 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 also may change your deductible, coinsurance and out-of-pocket limit values on an annual basis to reflect cost of living increases.

H. AMENDMENTS TO THIS CONTRACT

Amendments which we include with this Contract or send to you at a later date are incorporated and fully made a part of this Contract.

I. MASTER GROUP CONTRACT

The HealthPartners Master Group Contract combined with this Contract, any Amendments, the group dental plan sponsor's application, the individual applications of the enrollees and any other document referenced in the Master Group Contract constitute the entire contract between HealthPartners and HealthPartners Insurance Company and the group dental plan sponsor. This Master Group Contract is available for inspection at your group dental plan sponsor's office or at HealthPartners' and HealthPartners Insurance Company's home office, at 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309. The Master Group Contract is delivered in the State of Minnesota and governed by the laws thereof.

J. CONFLICT WITH EXISTING LAW

In the event that any provision of this Contract is in conflict with Minnesota or federal law, only that provision is hereby amended to conform to the minimum requirements of the law.

K. HOW TO USE THE NETWORK

This section contains information you need to know in order to obtain network benefits.

This Contract provides coverage for your services provided by our network of participating providers and facilities.

Network Provider. This is any one of the participating licensed dentists or other dental care providers or facilities listed in your network directory, which has entered into an agreement with HealthPartners to provide dental care services to members.

For groups subject to ERISA, a provider listing will be sent to you automatically and free of charge, as a separate document along with the Membership Contract.

Emergency care is available 24 hours a day, seven days a week.

Non-Network Providers. These are licensed dentists or other dental care providers, or facilities not participating as network providers.

ABOUT THE HEALTHPARTNERS NETWORK

To obtain HealthPartners Benefits for covered services, you must receive services from HealthPartners network providers. Under limited circumstances, we may authorize, at our discretion, the care delivered by non-network providers to be covered as HealthPartners benefits. There are limited exceptions as described in this Contract. You must verify that your provider participates with the HealthPartners network each time you receive services.

HealthPartners Dental Network. This is the network of participating providers described in the network directory.

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

HealthPartners Service Area. This is the geographical area in which we provide services to members. Contact Member Services for information regarding the service area.

Second Opinions for HealthPartners Services. If you question a decision by a HealthPartners network dentist about dental care, we cover a second opinion from a HealthPartners network dentist.

Referrals and Authorizations for HealthPartners Services. There is no referral requirement for services delivered by providers within your network. Your dentist will coordinate the authorization process for any services which must first be authorized. Under limited circumstances, we may authorize, at our discretion, the care delivered by non-network providers to be covered as HealthPartners benefits. **Referral:** This is a professional communication unrelated to benefits, introducing a patient to another provider, and requesting their involvement in the patient's care.

Our dental directors, or their designees, make coverage determinations and make final authorization for certain covered services. Coverage determinations are based on established dental policies, which are subject to periodic review and modification by the dental directors. Certain benefit limitations may be waived upon submission, by your dentist, of documentation of dental necessity.

Call Member Services at (952) 883-5000 or 1-800-883-2177 outside the metro area for more information on authorization requirements.

L. ACCESS TO RECORDS AND CONFIDENTIALITY

We comply with the state and federal laws governing the confidentiality and use of protected health information and dental records. When your provider releases health information to us according to state law, we can use your protected dental information, when necessary, for certain dental care operations, including: claims processing, including claims we make for reimbursement; quality of care assessment and improvement; accreditation, credentialing, case management, care coordination and utilization management, disease management, premium rating, claims experience reporting to your employer or other dental plan sponsor, (only upon certification by your employer or plan sponsor of the compliance of plan documents with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")), the evaluation of potential or actual claims against us, auditing and legal services, and other access and use without further authorization if permitted or required by another law. When you enrolled for coverage, you authorized our access to use your records as described in this paragraph, and this authorization remains in effect unless it is revoked.

M. 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 IV. "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 this Contract.

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 are 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.

II. DEFINITIONS OF TERMS USED

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.

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

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.

Covered Service. This is a specific dental service or item, which is medically or dentally necessary and covered by us, as specifically described in this Contract.

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 member's general health condition must permit the necessary procedure(s). Decisions about dental necessity are made by the HealthPartners Dental Director or his or her designee.

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.

Eligible Dependents. These are the persons shown below. Under this Contract, a person who is considered an enrollee is not qualified as an eligible dependent. A person who is no longer an eligible dependent (as defined below) on an enrollee's Contract may qualify for continuation of coverage within the group, as provided in section VII. of this Contract.

1. **Spouse.** This is an enrollee's current legal spouse. If both spouses are covered as enrollees under this Contract, only one spouse shall be considered to have any eligible dependents.

2. **Child.** This is an enrollee's (a) natural or legally adopted child (effective from the date placed for adoption); (b) child for whom the enrollee or the enrollee's spouse is the legal guardian; (c) a child covered under a valid qualified medical child support order (as the term is defined under Section 609 of the Employee Retirement Income Security Act (ERISA) and its implementing regulations) which is enforceable against an enrollee*; or (d) stepchild of the enrollee (that is, the child of the enrollee's spouse). In each case, the child must be either under 26 year of age or a disabled dependent, as described below.

   *(A description of the procedures governing qualified medical child support order determination can be obtained, without charge, from us.)

3. **Qualified Grandchild.** This is an enrollee's unmarried grandchild who is a newborn, and who resides with and is financially dependent on the covered grandparent. The grandchild must be either under 26 years of age or a disabled dependent, as described below.

4. **Disabled Dependent.** This is an enrollee's dependent who is (a) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and (b) chiefly dependent on the enrollee for support and maintenance. The enrollee must give us a written request for coverage of a disabled dependent. The request must include written proof of disability and must be approved by us, in writing. We must receive the request within 31 days of the date an already enrolled dependent becomes eligible for coverage under this definition, or when adding a new disabled dependent eligible under this definition. We reserve the right to periodically review disability, provided that after the first two years, we will not review the disability more frequently than once every 12 months.

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.

Enrollee. This is a person who is eligible through the group health plan sponsor's Master Group Contract, applies for membership and is accepted by us for coverage under this Contract.

Group Dental Plan Sponsor. This is the purchaser of this Contract's group dental coverage, which covers the enrollee and any eligible dependents.

Investigative: As determined by us, a drug, device or dental treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. We will consider the following categories of reliable evidence, none of which shall be determinative by itself:

1. Whether there is final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the United States Food and Drug Administration (FDA); if the drug or device or dental treatment or procedure is the subject of ongoing Phase I, II or III clinical trials; or if the drug, device or dental treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and

2. Whether there are consensus opinions or recommendations in relevant scientific, medical and/or dental literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether a drug is included in the American Hospital Formulary Service as appropriate for its proposed use; and

3. Whether there are consensus opinions of national and local health care providers in the applicable specialty as determined by a sampling of providers, including whether there are protocols used by the treating facility or another facility studying the same drug, device, dental treatment or procedure.

Medically Necessary Orthodontic Services. This is treatment necessary for the correction of severe malocclusion of teeth and associated dental and facial disfigurement, when such treatment is intended to correct congenital defects and anomalies, or the effects of disease, which result in a functional impairment. Functional impairments include, but are not limited to significant impairment in chewing, breathing or swallowing.

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

Member. This is the enrollee covered for benefits under this Contract, and all of his or her eligible and enrolled dependents. When used in this Contract, "you" or "your" has the same meaning as "member".

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 malocclusion of teeth and dental or facial disfigurement 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.

Waiting Period. This is, for a potential member, the period that must pass before the member is eligible, under the group dental plan sponsor's eligibility requirements, for coverage under this Contract.

III. SERVICES NOT COVERED

In addition to any other benefit exclusions, limitations or terms specified in this Contract, we will not cover charges incurred for any of the following services, except as specifically described in this Contract:

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 Benefits, treatment, procedures or services which are not provided 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. Inhaled nitrous oxide is not covered. General anesthesia and intravenous sedation are not covered except as indicated in the Benefits Chart.
7. Orthodontic services, except as provided in this Contract and the Benefits Chart.
8. Orthognathic surgery (surgery to reposition the jaws).
9. Services which are elective, investigative, experimental or not otherwise clinically accepted.
10. 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, except as covered orthodontic services provided in this Contract. Mandibular orthopedic appliances and bite planes are also not covered.
11. Procedures, appliances (other than occlusal guards, as indicated in the Benefits Chart) or restorations for the prevention of bruxism (grinding of teeth) or clenching.
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.
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. This includes all oral pathology and laboratory testing charges.
15. For non-network coverage, dental services related to the replacement of any teeth missing prior to the member's effective date under this Contract.
16. Dental services, supplies and devices not expressly covered as a benefit under this Contract and Benefits Chart.
17. Prescription drugs and medications prescribed by a dentist. This includes therapeutic drug injections.
18. Services provided to the member which the member is not required to pay.

19. 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.
20. 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.
21. Except where expressly addressed in the Benefits Chart, 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.
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. Treatment, procedures, or services or drugs which are provided when you are not covered under this Contract.
31. Cone beam x-rays.
32. Harvest of bone for use in autogenous grafting procedure.
33. Charges for maxillofacial prosthetics.
34. Charges for case presentations for treatment planning or behavioral management.
35. Charges for enamel microabrasion, odontoplasty and pulpal regeneration.
36. Charges for surgical procedures for isolation of a tooth with a rubber dam.
37. Non-intravenous conscious sedation and drugs to treat anxiety or pain.
38. Charges for endodontic endosseous implants.
39. Charges for intentional reimplantation (including necessary splinting).
40. Charges for canal preparation and fitting of preformed dowel or post.
41. Charges for temporary crowns for fractured teeth.
42. Charges for interim or custom abutments for implants.
43. Charges for rebonding, recementing and repair of fixed retainers.
44. Charges for surgical placement of a temporary anchorage device.
45. Charges for autogenous or nonautogenous osseous, osteoperiosteal or cartilage graft of the mandible or maxilla.
46. Charges for anatomical crown exposure.
47. Interim prostheses.
48. Connector bars, stress breakers and precision attachments.
49. Provisional pontics , crowns and retainer crowns.
50. Copings.
51. Oral hygiene instruction.
52. Removal of fixed space maintainers.
53. Hospital, home and extended care facility visits by dental providers.
54. Gold foil restorations.
55. Treatment for correction of malocclusion of teeth and associated dental and facial disharmonies, and post-treatment retainers, when treatment is not medically necessary.

IV. DISPUTES AND COMPLAINTS

A. DETERMINATION OF COVERAGE

Eligible services are covered only when dentally necessary for the proper treatment of a member. 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.

B. COMPLAINTS

1. In General: We have a complaint procedure to resolve claims and disputes between or on behalf of members, applicants and us. Complaints should be made in writing or orally. They may be dental or non-dental in nature, or may concern the provision of care, administrative actions, or claims related to this Contract. Our member complaint system is limited to members, applicants, former members, or anyone acting on behalf of a member, applicant or former member seeking to resolve a dispute which arose during their membership or application for membership.

2. Definitions:

Complaint. This is any grievance by a complainant, as defined below, against us which has been submitted by a complainant and which is not under litigation. Examples of complaints are the scope of coverage for dental care services; eligibility issues; denials, cancellations, or nonrenewals of coverage; administrative operations; and the quality, timeliness, and appropriateness of dental care services provided. If the complaint is from an applicant, the complaint must relate to the application. If the complaint is from a former enrollee, the complaint must relate to services received during the time the individual was an enrollee.

Complainant. This is an enrollee, applicant, or former enrollee, or anyone acting on behalf of an enrollee, applicant or former enrollee, who submits a complaint.

3. Complaint and Appeal Process

a. Complaints:

A complainant may submit a complaint to the Member Services Department either in writing or orally. A written complaint will be considered a first level appeal under the appeal process described in paragraph b. The Member Services Department will make every effort to resolve the complaint. The Member Services Department will investigate the complaint and provide for informal discussions. If the oral complaint is not resolved to the complainant's satisfaction within 10 calendar days of receipt of the complaint, we will provide an appeal form to the complainant, which must be completed and returned to the Member Services Department for further consideration. We will offer to assist the complainant in completing this form. We will also offer to complete the form and mail it to the complainant for a signature.

If your claim for dental services was denied based on our clinical coverage criteria, you or your provider can discuss the decision with a dentist who reviewed the request for coverage. Call Member Services for assistance.

At any time, the complainant may also file a complaint with the Commissioner of Health regarding HealthPartners network benefits, either in writing or by calling (651) 282-5608, or toll-free 1-800-657-3916 or the Commissioner of Commerce regarding Non-Network benefits at (651) 296-2488, or toll-free at 1-800-657-3602.

b. Appeals Process:

A complainant can seek further review of a complaint not resolved through the complaint process described above. The steps in this appeal process are outlined below.

i. First Level Appeal. You or your authorized representative may send your written request for review, including comments, documents, records and other information relating to the appeal, the reasons you believe you are entitled to benefits, and any supporting documents to:

HealthPartners/HealthPartners Insurance Company
Member Services Department
8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: (952) 883-5000 Outside the metro area: 1-800-883-2177

We will notify the complainant within 10 business days that we received the appeal, unless the appeal has been resolved to the complainant's satisfaction within those 10 business days.

Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your appeal, and you may also present evidence and testimony as part of the appeals process.

Concurrent Care Appeal. If you are appealing an ongoing course of treatment that has been previously approved by us, you will have continued coverage under the plan, pending the outcome of the appeal. This does not apply to requests for an extension to the already approved period or treatment or number of visits.

We will review your appeal and will notify you of our decision in accordance with the following timelines:

A decision on your appeal will be made within 30 calendar days.

This time period may be extended if you agree. If we request an extension, we will notify you in advance of the extension and the reasons for the extension.

All notification described above will comply with applicable law.

ii. Second Level Appeal. If you file a first level appeal relating to a health or dental care service or claim and it is denied, wholly or in part, you have the right to request external review of our decision without filing a second level appeal. See below for a description of this process. If your request was denied after the first level appeal of any other issue, you or your authorized representative may submit a written request for a second level appeal, including any relevant documents, and submit issues, comments and additional information as appropriate to:

HealthPartners/HealthPartners Insurance Company
Member Services Department
8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: (952) 883-5000 Outside the metro area: 1-800-883-2177

The Member Services Department will provide the complainant with the option of either a written reconsideration, or a hearing before the Member Appeals Committee either in person or over the telephone. Hearings and written reconsiderations shall include the receipt of testimony, correspondence, explanations, or other information from the complainant, staff persons, administrators, providers, or other persons, as is deemed necessary for a fair appraisal and resolution of the appeal. During your appeal, upon your request we will provide you, free of charge, reasonable access to all documents, records and other information relevant to your appeal.

We will review the appeal and written notice of the decision and all key findings will be given to the complainant within 30 calendar days of the Member Services Department's receipt of the complainant's written notice of appeal.

These time periods may be extended if you agree.

4. External Review Procedures:

You must request external review within six months from the date of the adverse determination.

Expedited external appeal. You have a right to request an expedited external review if you receive:

a. an adverse determination that involves a medical or dental condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the enrollee or would jeopardize the enrollee's ability to regain maximum function and the enrollee has simultaneously requested an expedited internal appeal;
b. an adverse determination that concerns an admission, availability of care, continued stay, or health or dental care service for which the enrollee received emergency services but has not been discharged from a facility; or
c. an adverse determination that involves a medical or dental condition for which the standard external review time would seriously jeopardize the life or health of the enrollee or jeopardize the enrollee's ability to regain maximum function.

The external review entity must make its expedited determination to uphold or reverse the adverse determination as expeditiously as possible but within no more than 72 hours after the receipt of the request for expedited review and notify the enrollee and the health plan company of the determination.

If the external review entity's notification is not in writing, the external review entity must provide written confirmation of the determination within 48 hours of the notification.

Except as specified above, the following provision apply to external appeals:

a. If your complaint is denied based on our dentally necessary criteria, you have the right to request external review upon receiving notice of our decision on your complaint.

   If your complaint is denied for any other reason, you have the right to request external review upon notice of our decision at the completion of our internal appeal process.

   However, if the complaint relates to a malpractice claim, the complaint shall not be subject to the Internal Complaint Process.

b. To initiate the external review process, you may submit a written request for an external review to the Commissioner of Health or Commissioner of Commerce. This written request must be accompanied by a $25 filing fee payable to the Center for Health Dispute Resolution. This fee may be waived by the Commissioner in cases of financial hardship. We must participate in this external review, and must pay the cost of the review which exceeds the $25 filing fee. If the adverse determination is completely reversed, the filing fee must be refunded. Filing fees are limited to $75 in a Contract year.

c. Upon receipt of the request for external review, the external reviewer must provide immediate notice of the review to the complainant and to us. Within 10 business days, the enrollee and HealthPartners must provide the reviewer with any information they wish to be considered. The enrollee (who may be assisted or represented by a person of their choice) and HealthPartners shall be given an opportunity to present their versions of the facts and arguments. Any aspect of the external review involving dental determinations must be performed by a dental care professional with expertise in the dental issue being reviewed.

d. An external review must be made as soon as possible, but no later than 40 days after receipt of the request for external review. Prompt written notice of the decision and the reasons for it must be sent to the enrollee, the Commissioner of Health or Commissioner of Commerce, and to us.

e. The results of the external review are non-binding on the enrollee and binding on us. We may seek judicial review on grounds that the decision was arbitrary and capricious or involved an abuse of discretion.

V. CONDITIONS

COORDINATION OF BENEFITS

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

Unless applicable federal or state law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under this Contract must provide any facts needed to pay the claim.

1. Applicability.

a. This coordination of benefits (COB) provision applies to this Contract when an enrollee or the enrollee's covered dependent has health or dental care coverage under more than one plan. "Plan" and "This Plan" are defined below.

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

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

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

2. Definitions.

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

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

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

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

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

c. **"Primary Plan/Secondary Plan"** The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more of the plans and may be a Secondary Plan as to a different plan or plans.

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

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

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

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

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

3. Order of Benefit Determination Rules.

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

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

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

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

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

(2) Dependent Child/Parents not Separated or Divorced. Except as stated in subparagraph b., (3.) below, when This Plan and another plan cover the same child as a dependent of different persons, called "parents":

(a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(b) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described in "(a.)" immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

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

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

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

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

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

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

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

4. Effect on the Benefits of This Plan.

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

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

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

(2) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

5. Right to Receive and Release Needed Information. Certain facts are needed to apply these COB rules. We have the right to decide which facts we need. Consistent with applicable state and federal law, we may get needed facts from or give them to any other organization or person, without your further approval or consent. Unless applicable federal or state law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under This Plan must give us any facts we need to pay the claim.

6. Facility of Payment. A payment made under another plan may include an amount which should have been paid under This Plan. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

7. Right of Recovery. If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of:

a. the persons it has paid or for whom it has paid;

b. insurance companies; or
c. other organizations.

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

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

VI. EFFECTIVE DATE AND ELIGIBILITY

A. EFFECTIVE DATE

Your coverage begins on the effective date contained in the information which accompanies your initial identification card. Your coverage is contingent upon fulfillment of the eligibility rules contained in the Master Group Contract and your coverage under our group medical plan offered with this pediatric dental plan.

If an enrollee is not actively at work on the effective date, coverage is delayed for the enrollee (and dependents) until the date of return to active work.

B. ELIGIBILITY

You must make written application to enroll yourself and any eligible dependents, and such application must be received by us within 31 days of the date you first become eligible, in order for coverage under this Contract to be effective on the eligibility date. Similarly, you must make written application to enroll a newly acquired dependent, and we must receive such written application and receive any required payments, if any, within 31 days of when you first acquire the dependent (e.g., through marriage), in order for coverage under this Contract to be effective on the eligibility date.

Late Enrollment. If you do not enroll yourself or any eligible dependents within 31 days of the date that you or your dependents first become eligible, you may enroll yourself and any eligible dependents during the annual open enrollment period or during a special enrollment period.

Special Enrollment Period. If you are eligible, but not enrolled for coverage under this Contract, or your dependent, if the dependent is eligible but not enrolled for coverage under this Contract, you or your dependent may enroll for coverage under the terms of this Contract if all of the following conditions are met:

a. you or your dependent were covered under a group health plan or had health insurance coverage at the time coverage was previously offered to you or your dependent;
b. you stated in writing at the time of initial eligibility that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the group health plan sponsor required this and provided you with notice of this requirement and the consequences of it;
c. you or your dependent's coverage described in a. above was:
   (1) under a COBRA continuation provision and that coverage was exhausted; or
   (2) not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, cessation of dependent status or reduction in the number of hours of employment; a situation in which the individual incurs a claim that would meet or exceed a lifetime limit on all benefits; a situation in which coverage is no longer offered to the class of similarly situated individuals that includes the individual; a situation in which an individual loses coverage through a health maintenance organization or other arrangement because that individual no longer resides, lives or works in the health maintenance organization's service area or a situation in which the individual's benefit option is terminated) or the employer contributions toward coverage were terminated; and
d. you requested this enrollment not later than 31 days after the date of exhaustion of coverage described in c. (1) above, or one of the events listed in c. (2) above.

Dependents may enroll if: (a) a group health plan makes coverage available with respect to your dependent; (b) you are covered under the Contract (or have met any waiting period applicable to becoming covered under the Contract and are eligible to be enrolled under the Contract but for a failure to enroll during a previous enrollment period); and (c) a person becomes your dependent through marriage, birth, or adoption or placement for adoption. This Contract shall provide for a dependent special enrollment period during which the person may be enrolled under this Contract as your dependent and in the case of the birth or adoption of a child, your spouse may be enrolled as your dependent if otherwise eligible for coverage. You may also enroll at this time. A dependent special enrollment period shall be a period of not less than 31 days and shall begin on the later of:

a. the date dependent coverage is made available; or
b. the date of the marriage, birth, or adoption or placement for adoption described in (c) in the paragraph above.

If an insured seeks to enroll a dependent during the first 31 days of a dependent special enrollment period, the coverage of the dependent shall become effective:

a. in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
b. in the case of a dependent's birth, as of the date of birth; or
c. in the case of a dependent's adoption or placement for adoption, the date of adoption or placement for adoption.

Newborn Enrollment. Newborn infants (including a newborn grandchild of a covered grandparent) and a newly adopted child, may be covered, regardless of when notice is received by us. However, we must receive required payments, if any, from the date of eligibility for a newborn infant (including a newborn grandchild of a covered grandparent) and a newly adopted child, before benefits will be paid. You must notify us immediately of any change in eligibility of an enrolled dependent.

There is no right of conversion for dental members.

C. CHANGES IN COVERAGE

If a change in coverage is requested by us or the group dental plan sponsor, it is effective on the group dental plan sponsor's Master Group Contract anniversary date, subject to our approval of that change, unless the provision pertaining to that change specifically provides otherwise. Any change in coverage required by state or federal law, becomes effective according to law. Any change in coverage made by us or the group dental plan sponsor requires 31 day advance written notice.

VII. CONTINUATION OF GROUP DENTAL COVERAGE

If your eligibility for group coverage under this Contract ends because of one of the events shown below, called "qualifying events", you may be eligible to continue group coverage. Each of these options is shown below.

A. CONTINUATION OF GROUP COVERAGE

1. Qualifying Events. Coverage under this Contract may be continued by an enrollee, spouse and other dependents, enrolled at the time coverage would otherwise end, as a result of one of the following qualifying events.

(a) Termination of employment (except for gross misconduct) of the enrollee, or reduction in hours resulting in a loss of group coverage.
(b) Death of the enrollee.
(c) Divorce or legal separation from the enrollee.
(d) Loss of eligibility as a dependent child.
(e) Initial entitlement of the enrollee for Medicare.
(f) For a retired enrollee, spouse and other dependents, the bankruptcy filing by a former employer, under Title XI, United States Code, on or after July 1, 1986.

2. Duration of Continuation Coverage. The maximum period coverage can be continued depends on the qualifying event. It may be terminated earlier as shown below. The maximum period of continuation coverage starts on the day of the qualifying event.

a. Maximum period.

(1) Termination and reduced hours. The maximum period of continuation coverage is 18 months. If a second qualifying event, other than the employer's bankruptcy, occurs during the 18 months, the maximum period of continuation coverage is 36 months. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".

(2) Disabled enrollee, spouse or dependent child. If the enrollee, spouse or other dependent is disabled under Title II or XVI of the Social Security Act, at any time during the first 60 days of continuation coverage, the 18-month maximum continuation period may be extended to 29 months. The disabled person must notify the group dental plan sponsor within 60 days of the date of determination of disability, and within the initial 18-month continuation period. If a second qualifying event (other than bankruptcy) occurs during the extended 29-month period, the maximum period of continuation coverage is 36 months. See part B. "Disabled Enrollee" below, which describes your rights for coverage as a disabled enrollee under Minnesota law.

(3) Bankruptcy. In the case of bankruptcy of a retired enrollee's former employer, the maximum period of continuation coverage is until the death of the retired enrollee. In the case of the surviving spouse or dependent children of the retired enrollee, the maximum period of continuation coverage is 36 months after the death of the retired enrollee.

(4) Divorce or legal separation. There is no maximum period of coverage for a former spouse or dependents, who lose coverage due to divorce or legal separation. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".

(5) Death of enrollee. There is no maximum period of coverage for a surviving spouse and dependents, who lose coverage due to the death of the enrollee. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".

(6) Other qualifying events. The maximum period of continuation coverage for all other qualifying events is 36 months.

b. Earlier Termination. Coverage terminates before the end of the maximum period if any of the following occurs.

(1) End of the plan. The group dental plan sponsor terminates the agreement under which this coverage is offered to its enrollees.

(2) Failure to pay enrollment payment. The person receiving continuation coverage does not make the monthly payment within 30 days of the due date.

(3) Other group dental coverage. The person receiving continuation coverage becomes covered under any other group dental type coverage, not containing an exclusion or limitation for any pre-existing condition of the person. If the other group coverage contains a pre-existing condition limitation, continuation coverage is extended until the pre-existing limitation is satisfied or coverage is otherwise terminated. A person will not be subject to earlier termination of continuation coverage on account of coverage under another group plan that existed prior to that person's first day of continuation coverage.

(4) Termination of extended coverage for disability. In case a person receives extended (29-month) continuation coverage due to disability at the time of termination or reduced hours, the extended coverage terminates at the beginning of the month, 30 days after a final determination that the person is no longer disabled. See part B. "Disabled Enrollee" below, which describes your rights for coverage as a disabled enrollee under Minnesota law.

(5) Termination provisions of this Contract. The person receiving continuation coverage moves out of the service area, or whose coverage is subject to termination for cause under section VIII. of this Contract.

3. Election of Continuation Coverage.

a. You have 60 days to elect continuation of group coverage. The 60-day period begins on the date your group coverage would otherwise terminate due to a qualifying event or the date on which written notice of your right of continued group coverage is received, whichever is later.

b If you wish to continue group coverage as shown above, you must apply in writing to your group dental plan sponsor (not us). You must also pay your first monthly payment within 45 days of the date you elected to continue group coverage. If your coverage was terminated because of the death of the enrollee, your initial payment is not due until 90 days after you receive notice of the continuation right. Thereafter, your monthly payments are due and payable at the beginning of each month for which coverage is to be continued.

c. You or your enrolled dependents must notify the group dental plan sponsor within 60 days when divorce, legal separation, change in status resulting in a loss of eligibility as a dependent would end coverage or a second qualifying event occurs. The 60 day period begins on the date of the divorce, legal separation, change in dependent status or second qualifying event.

4. Procedures for Providing Notices Required under this "Continuation of Group Coverage" section.

a. You must comply with the time limits for providing notices required in paragraph 3.c. above.

b. Your notice must be in writing and contain at least the following information:

(1) The names of the enrollee, covered spouse and other covered dependents;

(2) The qualifying event or disability; and
(3) The date on which the qualifying event (if any) occurred.

c. You must check with your employer for information regarding the person or entity that your notice should be sent to.

We will comply with applicable federal law for a covered employee that is called to active military duty in the uniformed services.

B. DISABLED ENROLLEE

Pursuant to the provisions of Minnesota Statute 62A.148, the group health plan sponsor and we agree not to terminate, suspend or otherwise restrict the participation in, or the receipt of, benefits otherwise payable hereunder, to any enrollee who becomes totally disabled while employed by the group health plan sponsor and covered hereunder while this Contract is in force, solely due to absence caused by such total disability. The group health plan sponsor may require the enrollee to pay all or some part of the payment for coverage in this instance. Such payment shall be made to the group health plan sponsor by that enrollee.

For the purpose of this section the term "total disability" means (a) the inability of an injured or ill enrollee to engage in or perform the duties of the enrollee's regular occupation or employment within the first two years of such disability and (b) after the first two years of such disability, the inability of the enrollee to engage in any paid employment or work for which the enrollee may, by education or training, including rehabilitative training, be or reasonably become qualified.

C. PUBLIC EMPLOYEES

Certain retired employees of public or governmental entities and their dependents may be eligible for continued coverage upon retirement, pursuant to Minnesota Statute 471.61. If you qualify under this law, you may be required to pay the entire premium for continued coverage and will be required to notify your employer within certain deadlines, of your intent to continue coverage.

VIII. TERMINATION

A member's coverage under this Contract terminates, when any of the following events occur.

1. The monthly enrollment payment is due on or before the beginning of the month during which coverage is in effect. There is a 31-day grace period during which to pay the required enrollment payment. This Contract continues in effect during that period. If no payment is received by us during the 31-day grace period, we will send the enrollee a notice of termination informing the enrollee of coverage termination 30 days from the date of notice for the enrollee and dependent. Coverage terminates, retroactive to the paid through date, but not more than 60 days prior to the end of the notice period. We are not obligated to accept any payment after the end of the grace period.

2. When an enrollee elects to terminate coverage under this Contract, coverage for the enrollee and all enrolled dependents terminates on the date specified by the enrollee, provided the enrollee has provided 14 days advance notice of termination. If an enrollee does not give 14 days' advance notice of termination, coverage under this Contract will terminate 14 days following the request for termination.

3. When an enrollee ceases to be eligible under the terms of the Master Group Contract, coverage for the enrollee and all enrolled dependents terminates on the last day of the month in which the enrollee's eligibility ceases, unless group continuation is elected, as shown in section VII. above.

4. When an enrolled dependent ceases to be eligible under the terms of the Master Group Contract, coverage terminates on the last day of the month in which the dependent's eligibility ceases, unless group continuation is elected, as shown in section VII. above.

5. When the eligibility period under the group continuation described in section VII. above expires for an enrollee or dependent.

6. When the Master Group Contract is terminated, either as requested by your group dental plan sponsor or us, in accordance with the terms of the Master Group Contract.

7. In the event of misrepresentation or omission of a material fact by a member regarding eligibility, enrollment, other coverage, claims or other expenses, we have the right to cancel or rescind this membership contract, or disenroll a member.

8. If you terminate your coverage under our group medical plan offered with this pediatric dental plan.

To the extent that a termination would be considered a rescission under federal law under items 2, 3 and 4 above, the group dental plan sponsor is required to give the insured 30 days advance notice of termination.

IX. CLAIMS PROVISIONS

1. Notice of Claims. When a claim arises, you should notify us of the charges incurred in writing. This written notice of claim must be given within 20 days after any charges incurred, which are covered by this section, or as soon as reasonably possible. **Notice given to us by you or on behalf of you, at HealthPartners' principal office at 8170 33rd Avenue South, P.O. Box 1172, Minneapolis, MN 55440-1172, with information sufficient to identify you and the service, is deemed notice.**

2. Claim Forms. After receiving notice of claim, we will furnish you a claim form for filing your proof of loss. If you do not receive this form within 15 days after notice is given to us, you should submit written proof which documents the date and type of service, provider name and itemized charges, for which a claim is made.

3. Proof of Loss. You must submit an itemized bill which documents the date and type of service, provider name and charges for covered services within 90 days of the loss. Bills must be submitted within 90 days after the date services were first received. If you do not furnish proof within 90 days as required, benefits shall still be paid for that loss if (1) it was not reasonably possible to give proof within those 90 days and (2) proof is furnished as soon as reasonably possible. Any bills for covered services must be submitted to the plan within 15 months of incurring the loss. Any bill received after 15 months from the date of service can be denied even if it is for a covered service, unless you were unable to submit the bill because you were legally incompetent or due to circumstances beyond your reasonable control.

4. Time of Payment of Claims. We will make payment promptly upon receipt of due written proof of loss. Benefits which are payable periodically during a period of continuing loss shall be payable on at least a monthly basis. We will notify you of our benefits determination if you have any remaining liability within 30 days of receipt of a completed claim. This time period may be extended by us for an additional 15 days for circumstances beyond our control.

5. Payment of Claims. All or any portion of any benefits provided on account of dental services may, at our option, be paid directly to the dentist or provider providing such services, but it is not required that the services be provided by a particular dentist or provider.

At our option, all payments for claims may be made directly to the provider of dental services, rather than to the enrollee, for claims incurred by a child, who is covered as a dependent of an enrollee who has legal responsibility for the dependent's dental care pursuant to a court order, provided we are informed of such order. This payment will discharge us from all further liability to the extent of the payment made.

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

X. STATEMENT OF ERISA RIGHTS

For group health plans that are subject to ERISA, federal law and regulations require that this "Statement of ERISA Rights" be included in this Group Membership Contract. This "Statement of ERISA Rights" is not applicable to group health plans that are not subject to ERISA. Your group health plan sponsor can tell you whether or not your plan is subject to ERISA. ERISA rights are in addition to any rights you may also have under state law; however, federal law may not invalidate, impair or supercede state law.

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and where applicable, copies of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and, where applicable, copies of the latest annual report (Form 5500) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights. See Section VII. of this Group Membership Contract.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health plan insurer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of non-privileged documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance With Your Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

XII. SPECIFIC INFORMATION ABOUT THE PLAN

The federal government requires that the following information be furnished for the Plan:

Name of the Plan:	See your employer's plan documents.
Address of the Plan:	See your employer's plan documents.
IRS Employer Identification Number:	See your employer's plan documents.
Plan Identification Number:	See your employer's plan documents.
Plan Year:	See your employer's plan documents.
Plan Fiscal Year Ends:	See your employer's plan documents.
Plan Administrator:	Your employer.
Agent for Service of Legal Process:	For this Group Membership Contract's benefits: HealthPartners For all other matters: your employer.
Named Fiduciary:	For this Group Membership Contract's benefits: HealthPartners For all other matters: your employer.
Funding:	This Group Membership Contract is fully insured under Minnesota law.
Network Providers:	HealthPartners Network
Contributions:	Employee and/or Employer.
Employment Waiting Period:	See your employer's plan documents.
Eligible Classes:	See your employer's plan documents.
Contact for Continuation of Coverage Notices:	See your employer's plan documents.

HealthPartners Pediatric Dental Plan
For Small Employers
Benefits Chart

Your Contract covers Preventive and Diagnostic Services, Basic, Special, Prosthetic and medically necessary Orthodontia Services only, for members under age 19.

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.

HealthPartners 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 Benefits Chart and the Membership 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 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. Coverage may vary according to your network selection.

HealthPartners Benefits are underwritten by HealthPartners, Inc. Non-Network Benefits are underwritten by HealthPartners Insurance Company.

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 the Benefits Chart. They also apply to the Contract.

Charge: For covered services delivered by participating network providers this 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, 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 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 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 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 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 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 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 our maximum amount allowed for the non-network provider. The 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 limit 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 our member services department for assistance in determining the amount paid by the member 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 contract.

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

Individual Calendar Year Deductible

HealthPartners Benefits	**Non-Network Benefits**
See your HealthPartners Benefits individual deductible under your HealthPartners Small Employer Medical Plan Benefits Chart.	See your Non-Network Benefits individual deductible under your HealthPartners Small Employer Medical Plan Benefits Chart.

Family Calendar Year Deductible

HealthPartners Benefits	**Non-Network Benefits**
See your HealthPartners Benefits family deductible under your HealthPartners Small Employer Medical Plan Benefits Chart.	See your Non-Network Benefits family deductible under your HealthPartners Small Employer Medical Plan Benefits Chart.

Individual Calendar Year Out-of-Pocket Limit

HealthPartners Benefits	Non-Network Benefits
See your HealthPartners Benefits individual out-of-pocket limit under your HealthPartners Small Employer Medical Plan Benefits Chart.	See your Non-Network Benefits individual out-of-pocket limit under your HealthPartners Small Employer Medical Plan Benefits Chart.

Family Calendar Year Out-of-Pocket Limit

HealthPartners Benefits	Non-Network Benefits
See your HealthPartners Benefits family out-of-pocket limit under your HealthPartners Small Employer Medical Plan Benefits Chart.	See your Non-Network Benefits family out-of-pocket limit under your HealthPartners Small Employer Medical Plan Benefits Chart.

A. 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: HealthPartners Benefits.

Routine dental care examinations for new and existing patients

HealthPartners Benefits	Non-Network Benefits
100% of the charges incurred, limited to twice each calendar year.	50% of the charges incurred, limited to twice each calendar year.

Dental cleaning (prophylaxis or periodontal maintenance cleaning)

HealthPartners Benefits	Non-Network Benefits
100% of the charges incurred, limited to twice each calendar year.	50% of the charges incurred, limited to twice each calendar year.

Professionally applied topical fluoride

HealthPartners Benefits	Non-Network Benefits
100% of the charges incurred, limited to twice each calendar year.	50% of the charges incurred, limited to twice each calendar year.

Pit and Fissure sealant application and preventive resin restoration

HealthPartners Benefits	Non-Network Benefits
100% of the charges incurred, limited to one application per tooth per 36-month period, for unrestored permanent molars.	50% of the charges incurred, limited to one application per tooth per 36-month period, for unrestored permanent molars.

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

HealthPartners Benefits	Non-Network Benefits
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

HealthPartners Benefits	Non-Network Benefits
100% of the charges incurred, limited to once every sixty months.	50% of the charges incurred, limited to once every sixty months.

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

HealthPartners Benefits	Non-Network Benefits
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 members under the age of 3 which include counseling with the primary caregiver

HealthPartners Benefits	Non-Network Benefits
100% of the charges incurred.	50% of the charges incurred.

Screening or assessments of a patient

HealthPartners Benefits	Non-Network Benefits
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 x-rays.
- Oral hygiene instruction.
- Removal of fixed space maintainers.
- Hospital, home and extended care facility visits by dental providers.
- See Services Not Covered in the Group Membership Contract Section III.

B. BASIC SERVICES

Covered Services:

We cover the following services:

Basic I Services

Emergency treatment for relief of pain

HealthPartners Benefits	Non-Network Benefits
75% of the charges incurred.	50% 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

HealthPartners Benefits	Non-Network Benefits
75% of the charges incurred.	50% of the charges incurred.

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

HealthPartners Benefits	Non-Network Benefits
75% of the charges incurred.	50% of the charges incurred.

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

HealthPartners Benefits	Non-Network Benefits
75% of the charges incurred.	50% of the charges incurred.

Periodontics (Gum Disease) - non-surgical treatment

HealthPartners Benefits	Non-Network Benefits
75% of the charges incurred, limited to once every 24 months for non-surgical treatment.	50% of the charges incurred, limited to once every 24 months for non-surgical treatment.

Endodontics I - Endodontic Pulp Therapy and Pulpotomy Services (other than pulpal regeneration)

HealthPartners Benefits	Non-Network Benefits
75% of the charges incurred.	50% of the charges incurred.

Endodontics II - All Other Endodontic Services (including pulpal regeneration)

HealthPartners Benefits	Non-Network Benefits
75% 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 is covered, when dentally necessary, when provided by the attending dentist in a dental office setting and required to perform a covered dental procedure

HealthPartners Benefits	Non-Network Benefits
75% of the charges incurred.	50% of the charges incurred.

Periodontics (Gum Disease) - surgical treatment

HealthPartners Benefits	Non-Network Benefits
75% of the charges incurred, limited to once every 36 months for surgical treatment.	50% of the charges incurred, limited to once every 36 months for surgical treatment.

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.
- See Services Not Covered in the Group Membership Contract Section III.

C. SPECIAL SERVICES

Covered Services:

We cover 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

HealthPartners Benefits	Non-Network Benefits
75% of the charges incurred.	50% of the charges incurred.

Repair or recementing of crowns, inlays and onlays

HealthPartners Benefits	Non-Network Benefits
75% of the charges incurred.	50% of the charges incurred.

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 Contract or not.

Not Covered:

- Gold foil restorations.
- Services for replacement of any missing, lost or stolen dental or implant-supported prosthesis.
- Services related to a special restorative appliance which was installed or delivered more than 60 days after termination of coverage.
- See Services Not Covered in the Group Membership Contract Section III.

D. 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.

HealthPartners Benefits	**Non-Network Benefits**
75% 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.

HealthPartners Benefits	**Non-Network Benefits**
75% 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.

HealthPartners Benefits	**Non-Network Benefits**
75% of the charges incurred.	50% of the charges incurred.

Occlusal guards – occlusal guards for the treatment of bruxism and temporomandibular joint dysfunction are covered, including repair and relining of occlusal guards.

HealthPartners Benefits	Non-Network Benefits
75% 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 5 year period measured from the date on which it was installed, whether under this Contract or not.
- Occlusal guards are limited to one every 12 months, for members age 13 or older.

Not Covered:

- Onlays, veneers or partial crowns fabricated from extraorally cured composite resin or porcelain.
- 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.
- See Services Not Covered in the Group Membership Contract Section III.

E. DENTAL IMPLANT SERVICES

Covered Services:

We cover, **if dentally necessary**:

(1) the surgical placement of an implant body to replace missing natural teeth;
(2) 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;
(3) initial installation of implant-supported prosthesis (crowns, bridgework and dentures) to replace missing teeth;
(4) 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;
(5) repair of implant-supported prosthesis;
(6) other related implant services.

Decisions about dental necessity are made by HealthPartners' Dental Director, or his or her designee. If the Dental Director or his or her designee determines 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.

HealthPartners Benefits	Non-Network Benefits
75% 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 Contract or not.
- Endosteal implants, surgical placement of an interim implant body, eposteal implants, transolsteal 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.
- See Services Not Covered in the Group Membership Contract Section III.

F. EMERGENCY DENTAL CARE SERVICES

Covered Services

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

HealthPartners Benefits	**Non-Network Benefits**
Coverage level is the same as corresponding HealthPartners 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 Group Membership Contract Section III.

G. ORTHODONTIC SERVICES

Covered Services:

We cover medically necessary orthodontic services necessary for the correction of severe malocclusion of teeth and associated dental and facial disfigurement. Orthodontia may be considered medically necessary when the treatment is intended to correct congenital defects and anomalies, or the effects of disease, when they result in a functional impairment. Functional impairments include but are not limited to significant impairment in chewing, breathing or swallowing. Each orthodontic treatment includes:

(1) treatment necessary for the correction of malocclusion of teeth and associated dental and facial disfigurement;
(2) initial post-treatment retainers.

Benefits will be paid over the course of orthodontic treatment.

HealthPartners Benefits	**Non-Network Benefits**
75% of the charges incurred.	No Coverage.

Limitations

- Coverage under HealthPartners Benefits for Orthodontic Services begins after twenty-four months of the member's continuous enrollment under this dental benefit.

Not Covered:

- Treatment for correction of malocclusion of teeth and associated dental and facial disharmonies, and post-treatment retainers, when treatment is not medically necessary.
- Charges for rebonding, recementing and repair of fixed retainers.
- See Services Not Covered in the Group Membership Contract Section III.