Dental Benefits Chart

Group Name: Roseville Area Schools ISD 623 dba Roseville Area Schools 623

Group Number: 0311

Effective Date: The later of July 1, 2026 and the Covered Person's effective date of coverage under the Dental Plan.

UNDERSTANDING YOUR COVERAGE

This Benefits Chart is the part of the Summary Plan Description (SPD) that explains how this Plan will pay for Dentally Necessary services. Covered Services are based on the conditions, limitations and exclusions in this Benefits Chart and other sections of the SPD. To receive coverage, the Date of Service must be while you are enrolled in this Plan.

HOW TO USE THIS BENEFITS CHART

This Benefits Chart is divided into sections based on different types of care or services. Each section includes the amount or percentage the Plan pays for Covered Services when received from Network and Out-of-Network Providers. When needed, sections will also include specific limitations or conditions for that coverage. You are responsible for the specified percentage of Charges that the Plan does not pay. You are also responsible for all Charges related to any non-covered services. Please refer to any "Not Covered" lists in each benefit category as well as the "Services Not Covered" section to better understand your coverage.

Certain capitalized words have special meanings. These words are defined in "General Definitions". Additional terms are defined in the SPD.

HOW YOUR CHOICE OF PROVIDERS AFFECTS YOUR COVERAGE

How much you pay for Covered Services may vary depending on whether you select a Network Provider or an Out-of-Network Provider. Your benefits could be greatly reduced when you use Out-of-Network Providers. This means you will have to pay more in out-of-pocket expenses. Most Out-of-Network Providers do not have an agreement with HealthPartners to provide services at a discounted fee.

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

In addition, when you receive care from most Out-of-Network Providers, the Plan will only pay up to the maximum amount. This is explained in more detail in the Plan's definition of Charge. The maximum amount can be significantly lower than an Out-of-Network Provider's billed Charges. If the Out-of-Network Provider's billed Charges are over the maximum amount, you pay all of the difference. You also pay any required Deductible or Coinsurance. Charges above the maximum amount do not apply to your Deductible.

For questions about coverage under the Plan, contact Member Services at the number on the back of your ID card.

GENERAL DEFINITIONS

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

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

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

For Covered Services delivered by Out-of-Network Providers, this is the provider's charge for a given dental/surgical service, procedure or item, up to the Plan's maximum amount allowed for that service, procedure or item.

The Plan's maximum amount allowed is based on the usual and customary charge for a given dental/surgical service, procedure, or item. This is the maximum amount the Plan considers in the calculation of payment of charges incurred for certain Covered Services. It is consistent with the charge of other providers of a given service or item in the same region. You must pay for any charges above the maximum amount allowed.

To be covered, a charge must be incurred on or after your effective date and on or before the termination date.

For Network Provider charges, the amount of the Coinsurance, or the amount applied to any 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 Out-of-Network Provider charges, the amount considered as Coinsurance, or the amount applied to any Deductible, is based on the lesser of the billed charge and the Plan's maximum amount allowed.

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.

Coinsurance. A percentage of Charges incurred for Covered Services, which the Plan does not pay, but which a Covered Person must pay, each time a Covered Person receives certain dental services, procedures or items. The Plan's payment for those Covered Services or items begins after the coinsurance is satisfied. Covered Services or items requiring coinsurance are specified in this Benefits Chart. A coinsurance is due at the time a service is rendered, or when billed by the provider.

For services provided by a Network Provider: An amount which is listed as a percentage of Charges or coinsurance is based on the Network Provider's discounted Charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule rate.

For services provided by an Out-of-Network Provider: Any coinsurance is applied to the lesser of the provider's Charges or the maximum amount allowed for a service.

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

Cosmetic. This is dental care or services to improve appearance, without treatment of a covered dental service.

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

Deductible. The specified dollar amount of Charges incurred for Covered Services, which the Plan does not pay, but a Covered Person or a family has to pay first in a Calendar Year. The Plan's payment for those services or items begins after any deductible is satisfied.

The Plan has an embedded deductible. This means once a Covered Person meets the individual deductible, the Plan begins paying benefits for that person. If multiple members of the family meet the family deductible, the Plan begins paying benefits for all members of the family, regardless of whether each Covered Person has met the individual deductible. However, a Covered Person may not contribute more than the individual deductible towards the family deductible.

The amount of the Charges that apply to any deductible are based on:

- The agreed fee applicable to the Network Provider, or a reasonable estimate of the cost according to a fee schedule equivalent
- The lesser of the billed Charge and the Plan's maximum amount allowed for the Out-of-Network Provider

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 Covered Person's general health condition must permit the necessary procedure(s). Decisions about dental necessity are made by a HealthPartners dental director or their designee, subject to final coverage determination by the Plan Sponsor.

The fact that an authorized Network or Out-of-Network Provider prescribes treatment does not necessarily mean the treatment is covered under this Plan.

Elective Services. These are services that are available to patients but are not Dentally Necessary.

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

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

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

Investigative. As determined by HealthPartners, a drug, device, or dental treatment is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or positive effect on health outcomes and will be considered investigative unless all of the following categories of reliable evidence are met:

- 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).
- The drug or device or dental treatment or procedure is not the subject of ongoing Phase I, II or III clinical trials
- The drug, device or dental treatment or procedure is not under study and further studies are not needed (such as post-marketing clinical trial requirements) to determine maximum tolerated dose, toxicity, safety, effect on health outcomes or efficacy as compared to existing standard means of treatment or diagnosis
- There is conclusive evidence in major peer-reviewed medical journals demonstrating the safety, effectiveness and positive effect on health outcomes (the beneficial effects outweigh any harmful effects) of the service or treatment when compared to standard established service or treatment. Each article must be of well-designed investigations, using generally acceptable scientific standards that have been produced by nonaffiliated, authoritative sources with measurable results. Case reports do not satisfy this criterion.

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, placement of dental implants or surgical care that is necessary because of a medical condition.

Orthodontics. This is dental care for the prevention, or correction of malocclusion of teeth and dental or facial disharmonies using appliances and techniques that alter the position of teeth in the jaws, including:

- Limited orthodontics. This is treatment with a limited objective, not involving the entire dentition.
- Interceptive orthodontics. This is treatment that is performed to lessen the severity or future effects of a malformation. Treatment may occur in the primary or transitional dentition.
- Comprehensive orthodontics. This includes multiple phases of treatment provided at different stages of development.

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.

DEDUCTIBLES AND CALENDAR YEAR MAXIMUM BENEFITS

Individual Calendar Year Deductible

Network Benefits	Out-of-Network Benefits
Benefit Level 1:	$25
None.	
Benefit Level 2:	
$25	

Deductibles under Network Benefit Levels 1 and 2 and Out-of-Network Benefits are combined.

Family Calendar Year Deductible

Network Benefits	Out-of-Network Benefits
Benefit Level 1:	$75
None.	
Benefit Level 2:	
$75	

Deductibles under Network Benefit Levels 1 and 2 and Out-of-Network Benefits are combined.

Individual Calendar Year Maximum Benefit

Network Benefits	Out-of-Network Benefits
Benefit Level 1:	$1,000
$2,000	
Benefit Level 2:	
$1,000	

The Individual Calendar Year Maximum Benefits under Network Benefit Levels 1 and 2 and Out-of-Network Benefits are combined.

YOUR BENEFITS

The Plan provides coverage for the following services based on the conditions, limitations and exclusions in this Benefits Chart and other sections of the SPD. Please refer to any "Not Covered" lists within individual benefit categories as well as the "Services Not Covered" section to better understand the coverage available to you.

Except where expressly addressed in this Benefits Chart, when multiple, acceptable treatment options exist related to a specific dental problem, the Plan will provide benefits based upon the least costly alternative treatment. This includes inlay restorations paid as corresponding amalgam restorations.

Your Plan covers Emergency Dental Care provided by Network Providers or Out-of-Network Providers to the same extent as eligible dental services and subject to the same Deductibles, Coinsurance and maximums.

Limits and maximums shown in this Benefits Chart are combined under your Network Benefits and Out-of-Network Benefits. Eligible Network care claims contribute to the Out-of-Network Deductible and Maximum Benefit and eligible Out-of-Network care claims contribute to the Network Deductible and Maximum Benefit.

PREVENTIVE AND DIAGNOSTIC SERVICES

Covered Services:

The Plan covers the following preventive and diagnostic services, with certain limitations which are listed below.

Routine dental care examinations for new and existing patients

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 100% of the Charges incurred, limited to twice each Calendar Year. **Benefit Level 2:** 100% of the Charges incurred, limited to twice each Calendar Year. Deductible does not apply.	100% of the Charges incurred, limited to twice each Calendar Year. Deductible does not apply. Charges are based on the maximum amount allowed. See the definition of Charge.

Dental cleaning (prophylaxis or periodontal maintenance cleaning)

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 100% of the Charges incurred, limited to twice each Calendar Year. **Benefit Level 2:** 100% of the Charges incurred, limited to twice each Calendar Year. Deductible does not apply.	100% of the Charges incurred, limited to twice each Calendar Year. Deductible does not apply. Charges are based on the maximum amount allowed. See the definition of Charge.

Professionally applied topical fluoride (other than silver diamine fluoride)

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 100% of the Charges incurred, limited to once each Calendar Year, for Covered Persons age 18 or younger. **Benefit Level 2:** 100% of the Charges incurred, limited to once each Calendar Year for Covered Persons age 18 or younger. Deductible does not apply.	100% of the Charges incurred, limited to once each Calendar Year for Covered Persons age 18 or younger. Deductible does not apply. Charges are based on the maximum amount allowed. See the definition of Charge.

Silver diamine fluoride

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 100% of the Charges incurred, limited to twice per tooth each Calendar Year. **Benefit Level 2:** 100% of the Charges incurred, limited to twice per tooth each Calendar Year. Deductible does not apply.	100% of the Charges incurred, limited to twice per tooth each Calendar Year. Deductible does not apply. Charges are based on the maximum amount allowed. See the definition of Charge.

Pit and fissure sealant application and preventive resin restoration

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 100% of the Charges incurred, limited to one application per tooth per three-year period, for permanent molars. **Benefit Level 2:** 100% of the Charges incurred, limited to one application per tooth per three-year period, for permanent molars. Deductible does not apply.	100% of the Charges incurred, limited to one application per tooth per three-year period, for permanent molars. Deductible does not apply. Charges are based on the maximum amount allowed. See the definition of Charge.

Bitewing x-rays

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 100% of the Charges incurred, limited to once each Calendar Year. **Benefit Level 2:** 100% of the Charges incurred, limited to once each Calendar Year. Deductible does not apply.	100% of the Charges incurred, limited to once each Calendar Year. Deductible does not apply. Charges are based on the maximum amount allowed. See the definition of Charge.

Full mouth or panoramic x-rays

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 100% of the Charges incurred, limited to once every three years. **Benefit Level 2:** 100% of the Charges incurred, limited to once every three years. Deductible does not apply.	100% of the Charges incurred, limited to once every three years. Deductible does not apply. Charges are based on the maximum amount allowed. See the definition of Charge.

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

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 100% of the Charges incurred. **Benefit Level 2:** 100% of the Charges incurred. Deductible does not apply.	100% of the Charges incurred. Deductible does not apply. Charges are based on the maximum amount allowed. See the definition of Charge.

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

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 100% of the Charges incurred, for Covered Persons age 18 or younger. **Benefit Level 2:** 100% of the Charges incurred, for Covered Persons age 18 or younger. Deductible does not apply.	100% of the Charges incurred, for Covered Persons age 18 or younger. Deductible does not apply. Charges are based on the maximum amount allowed. See the definition of Charge.

Oral hygiene instruction

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 100% of the Charges incurred, limited to once per lifetime as an independent procedure. **Benefit Level 2:** 100% of the Charges incurred, limited to once per lifetime as an independent procedure. Deductible does not apply.	100% of the Charges incurred, limited to once per lifetime as an independent procedure. Deductible does not apply. Charges are based on the maximum amount allowed. See the definition of Charge.

Evaluations that are not routine and periodic, including: problem-focused evaluations (either limited or detailed and extensive), periodontal evaluations, and evaluations for Covered Persons age 2 and younger which include counseling with the primary caregiver.

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 100% of the Charges incurred. **Benefit Level 2:** 100% of the Charges incurred. Deductible does not apply.	100% of the Charges incurred. Deductible does not apply. Charges are based on the maximum amount allowed. See the definition of Charge.

Screening or assessments of a patient.

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 100% of the Charges incurred, limited to twice each Calendar Year. **Benefit Level 2:** 100% of the Charges incurred, limited to twice each Calendar Year. Deductible does not apply.	100% of the Charges incurred, limited to twice each Calendar Year. Deductible does not apply. Charges are based on the maximum amount allowed. See the definition of Charge.

Not Covered:

- Repair or replacement of space maintainers
- Diagnostic testing that is performed and billed as a separate procedure such as collection of microorganisms for culture, viral cultures, genetic testing for susceptibility or oral disease and caries susceptibility tests. This includes all oral pathology and laboratory testing Charges.
- Non-dental administrative costs, including but not limited to:
  - Dental record preparation or mailing
  - Appointment cancellation fees
  - After hours appointment Charges
- Charges for observation
- Maxillofacial MRI
- Maxillofacial ultrasound
- Sialoendoscopy capture and interpretation
- Post processing of image or image sets
- Caries risk assessment and documentation

BASIC SERVICES

Covered Services:

Basic I Services

Consultations

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 100% of the Charges incurred. **Benefit Level 2:** 70% of the Charges incurred, after you pay the Deductible.	70% of the Charges incurred, after you pay the Deductible. Charges are based on the maximum amount allowed. See the definition of Charge.

Emergency treatment for relief of pain

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 100% of the Charges incurred. **Benefit Level 2:** 70% of the Charges incurred, after you pay the Deductible.	70% of the Charges incurred, after you pay the Deductible. Charges are based on the maximum amount allowed. See the definition of Charge.

Silver fillings on any tooth and tooth-colored fillings on anterior teeth. Restorations using Customary Restorative Materials and stainless steel crowns are covered, when Dentally Necessary due to loss of tooth structure as a result of tooth decay or fracture.

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 100% of the Charges incurred. **Benefit Level 2:** 70% of the Charges incurred, after you pay the Deductible.	70% of the Charges incurred, after you pay the Deductible. Charges are based on the maximum amount allowed. See the definition of Charge.

White (tooth-colored) fillings on bicuspids and molars. Restorations using Customary Restorative Materials are covered, when Dentally Necessary due to loss of tooth structure as a result of tooth decay or fracture.

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 60% of the Charges incurred. **Benefit Level 2:** 50% of the Charges incurred, after you pay the Deductible.	50% of the Charges incurred, after you pay the Deductible. Charges are based on the maximum amount allowed. See the definition of Charge.

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

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 80% of the Charges incurred. **Benefit Level 2:** 60% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible. Charges are based on the maximum amount allowed. See the definition of Charge.

Periodontics (gum disease) - non-surgical treatment

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 80% of the Charges incurred, limited to once in two years for non-surgical treatment. **Benefit Level 2:** 60% of the Charges incurred, after you pay the Deductible, limited to once in two years for non-surgical treatment.	60% of the Charges incurred, after you pay the Deductible, limited to once in two years for non-surgical treatment. Charges are based on the maximum amount allowed. See the definition of Charge.

Endodontics (root canal therapy)

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 80% of the Charges incurred. **Benefit Level 2:** 60% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible. Charges are based on the maximum amount allowed. See the definition of Charge.

Basic II Services

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

Dental reconstructive surgical procedures are covered when the dental procedure is performed on a Covered Dependent Child because of a congenital disease or anomaly which resulted in a functional defect as determined by the attending physician.

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 80% of the Charges incurred. **Benefit Level 2:** 60% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible. Charges are based on the maximum amount allowed. See the definition of Charge.

Cone beam CT capture and interpretation, when used for dental implants or extraction of impacted teeth and authorized by a HealthPartners dental director or their designee

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 80% of the Charges incurred. **Benefit Level 2:** 60% of the Charges incurred, after you pay the Deductible.	No coverage.

Periodontics (gum disease) - surgical treatment

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 80% of the Charges incurred, limited to once in two years for surgical treatment. **Benefit Level 2:** 60% of the Charges incurred, after you pay the Deductible, limited to once in two years for surgical treatment.	60% of the Charges incurred, after you pay the Deductible, limited to once in two years for surgical treatment. Charges are based on the maximum amount allowed. See the definition of Charge.

Not Covered:

- Periodontal splinting
- Orthognathic Surgery
- Procedures, appliances or restorations for the prevention of bruxism (grinding of teeth) or clenching
- Charges for:
  - Harvest of bone for use in autogenous grafting procedures
  - Surgical procedures for isolation of a tooth with a rubber dam
  - Placement of a restorative foundation for an indirect restoration
  - Periradicular services and bone grafts or other material used in conjunction with periradicular surgery
- Cone beam CT capture and interpretation, except when authorized by a HealthPartners dental director, or their designee
- Cone beam CT interpretation if billed separately
- Cone beam capture and interpretation for TMJ series

SPECIAL SERVICES

Covered Services:

Special restorative care. Extraorally fabricated or cast restorations (crowns, onlays) are covered when teeth cannot be restored with Customary Restorative Material and when Dentally Necessary due to the loss of tooth structure as a result of tooth decay or fracture. If a tooth can be restored with a Customary Restorative Material, but an onlay, crown, jacket, indirect composite or porcelain/ceramic restoration is selected, benefits will be calculated using the Charge appropriate to the equivalent Customary Restorative Material.

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 60% of the Charges incurred. **Benefit Level 2:** 50% of the Charges incurred, after you pay the Deductible.	50% of the Charges incurred, after you pay the Deductible. Charges are based on the maximum amount allowed. See the definition of Charge.

Repair or recementing of crowns, inlays and onlays

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 60% of the Charges incurred. **Benefit Level 2:** 50% of the Charges incurred, after you pay the Deductible.	50% of the Charges incurred, after you pay the Deductible. Charges are based on the maximum amount allowed. See the definition of Charge.

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 Plan or not
- A crown or onlay must be installed within 60 days after termination of coverage

PROSTHETIC SERVICES

Covered Services:

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

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 50% of the Charges incurred. **Benefit Level 2:** 50% of the Charges incurred, after you pay the Deductible.	50% of the Charges incurred, after you pay the Deductible. Charges are based on the maximum amount allowed. See the definition of Charge.

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

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 50% of the Charges incurred. **Benefit Level 2:** 50% of the Charges incurred, after you pay the Deductible.	50% of the Charges incurred, after you pay the Deductible. Charges are based on the maximum amount allowed. See the definition of Charge.

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

Network Benefits	Out-of-Network Benefits
Benefit Level 1: 50% of the Charges incurred. **Benefit Level 2:** 50% of the Charges incurred, after you pay the Deductible.	50% of the Charges incurred, after you pay the Deductible. Charges are based on the maximum amount allowed. See the definition of Charge.

Limitations:

- Benefit for replacement of a prosthetic appliance will be provided only:
  - If the existing appliance cannot be made serviceable
  - After a five-year period measured from the date on which it was installed, whether under this Plan or not
- A prosthetic appliance must be installed or delivered within 60 days after termination of coverage

Not Covered:

- Replacement of any missing, lost or stolen dental or implant-supported prosthesis

DENTAL IMPLANT SERVICES

Covered Services:

- The surgical placement of an implant body to replace missing natural permanent teeth other than congenitally missing teeth
- Removal and replacement of an implant body that is not serviceable and cannot be repaired after a period of at least five years from the date that the implant body was initially placed
- Initial installation of implant-supported prosthesis (crowns, bridgework and dentures) to replace missing teeth

- Replacement of an existing implant-supported prosthesis by a new implant-supported prosthesis, or the addition of teeth to an existing implant-supported prosthesis. The Plan will replace an existing implant-supported prosthesis when satisfactory evidence is presented that:
  - The new implant-supported prosthesis is required to replace one or more teeth extracted after the existing implant-supported prosthesis was installed
  - The existing implant-supported prosthesis cannot be made serviceable
- Repair of implant-supported prosthesis

Network Benefits	**Out-of-Network Benefits**
Benefit Level 1: 50% of the Charges incurred. **Benefit Level 2:** 50% of the Charges incurred, after you pay the Deductible.	50% of the Charges incurred, after you pay the Deductible. Charges are based on the maximum amount allowed. See the definition of Charge.

Limitations:

- Any benefit for replacement of an implant-related service or grafting related to implants will be provided only after a five year period measured from the date the service was provided, whether under this Plan or not

Not Covered:

- The surgical placement of a dental implant body and all associated dental implant-related services to replace missing primary natural teeth or congenitally missing permanent natural teeth
- Services related to treatment planning and implant case planning

CLEFT LIP AND CLEFT PALATE SERVICES

Covered Services:

The Plan covers dental services for treatment of cleft lip and cleft palate of a dependent Child, to the limiting age in the definition of an Eligible Dependent. Benefits are limited to expenses arising from dental treatment that was scheduled or initiated prior to the dependent turning age 19. If Orthodontic Services are eligible for coverage under this Plan and another policy or contract, this dental Plan shall be primary and the other policy or contract shall be secondary in regard to the coverage described above. Payment for dental or Orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate shall not be covered under this benefit.

Network Benefits	**Out-of-Network Benefits**
Coverage level is the same as corresponding Network Benefits depending on the type of service provided, such as Basic Services, Special Services or Orthodontic Services, if applicable.	Coverage level is the same as corresponding Out-of-Network Benefits depending on the type of service provided, such as Basic Services, Special Services or Orthodontic Services, if applicable.

ORTHODONTIC SERVICES

Covered Services:

The Plan covers treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies to the age limit and Orthodontic maximum shown below. The Plan only covers Orthodontic treatment that involves direct, in-person oversight with ongoing supervision by a licensed orthodontist or Dentist who is providing the treatment plan. Each limited, interceptive or comprehensive Orthodontic treatment includes:

- Treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies, to the age limit and Orthodontic maximum shown below
- Initial post-treatment retainers

The Plan pays up to the Orthodontic maximum, less the total amount of any benefit received for Orthodontic treatment under any prior dental coverage provided by the Plan Sponsor. It is the Covered Person's responsibility to provide documentation of benefits received under prior coverage. Benefits will be paid over the course of Orthodontic treatment.

Network Benefits	**Out-of-Network Benefits**
Benefit Level 1: For Covered Dependent Children age 18 or younger: 50% of the Charges incurred. **Benefit Level 2:** For Covered Dependent Children age 18 or younger: 50% of the Charges incurred. Deductible does not apply.	For Covered Dependent Children age 18 or younger: 50% of the Charges incurred. Deductible does not apply. Charges are based on the maximum amount allowed. See the definition of Charge.

Lifetime Maximum

Network Benefits	**Out-of-Network Benefits**
Benefit Level 1: $1,500 **Benefit Level 2:** $1,500	$1,500

Not Covered:

- Charges for fixed or removable appliances to control harmful habits such as tongue thrusting or thumb sucking

SERVICES NOT COVERED

This is one of several sections you need to review to understand your benefits and what you will pay when you receive care. Please also refer to any "Not Covered" lists within individual benefit categories.

Unless the Plan is mandated or required to provide coverage based on state or federal law, no benefits will be provided for any of the services, treatments, items or supplies described in this section. This is true even if a Dentist or dental care provider recommends or orders it.

To help you find exclusions in this section, this Benefits Chart uses headings. A heading does not define, change or limit an exclusion. All exclusions in this section apply to you.

Call Member Services at the number on the back of your ID card if you have questions about what is covered.

Anesthesia and Hospitalization

- Hospitalization or other facility Charges
- Local anesthesia or use of electronic analgesia billed as a separate procedure
- Nitrous oxide, unless Dentally Necessary and required to perform a covered dental procedure
- General anesthesia and intravenous sedation, except as indicated in this Benefits Chart
- Non-intravenous conscious sedation for Covered Persons age 19 or older

Providers/Network

- Network Benefits for services received from Out-of-Network Providers
- Services from providers or facilities that are not licensed
- Services outside the scope of practice or license of the individual or facility providing the services

Types of care

- Orthodontic Services, except as provided in this Benefits Chart
- Orthognathic Surgery
- Periodontal splinting
- Prescription drugs and medications prescribed by a Dentist. This includes gingival irrigation.
- Maxillofacial prosthetics
- Cone beam CT capture and interpretation, except when authorized by a HealthPartners dental director, or their designee
- Cone beam CT interpretation if billed separately
- Cone beam capture and interpretation for TMJ series
- Sinus augmentation
- Dental services or supplies primarily intended to alter the shape, appearance and function of the teeth 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, and any services intended to replace existing restorations done historically for Cosmetic reasons, even if due to material failure (wear/chipping/fracture) or the presence of decay at the restorative margin.
- Procedures, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (including chipping or fractures of tooth structure or restorations), or erosion, abfraction, abrasion, or realigning teeth, except as covered Orthodontic Services provided in this Benefits Chart
- Mandibular orthopedic appliances and bite planes
- Procedures, appliances or restorations for the prevention of bruxism (grinding of teeth) or clenching
- Athletic mouthguards
- Charges for fixed or removable appliances to control harmful habits such as tongue thrusting or thumb sucking
- Diagnostic testing that is performed and billed as a separate procedure such as collection of microorganisms for culture, viral cultures, genetic testing for susceptibility to oral disease and caries susceptibility tests. This includes all oral pathology and laboratory testing charges.
- Maxillofacial MRI
- Maxillofacial ultrasound
- Sialoendoscopy capture and interpretation
- Harvest of bone for use in autogenous grafting procedure
- Enamel microabrasion, odontoplasty and pulpal regeneration
- Surgical procedures for isolation of a tooth with a rubber dam

- Placement of a restorative foundation for an indirect restoration
- Periradicular services and bone grafts or other material used in conjunction with periradicular surgery
- Cleaning and inspection of a removable appliance
- Diagnostic casts, other than for Orthodontic treatment

All other exclusions

- Out-of-Network dental services related to the replacement of any teeth missing prior to the Covered Person's effective date under this Plan. An existing dental implant will be treated as an existing tooth and will not be considered a missing tooth.
- Services covered under the patient's medical plan, except to the extent not covered under the patient's medical plan
- Treatment, procedures, services or drugs which are provided when you are not covered under this Plan
- Dental services, supplies and devices not expressly covered as a benefit under the SPD and this Benefits Chart
- Services associated with non-covered services
- Treatment, procedures, services or drugs that do not meet the Plan's definition of Dentally Necessary as explained in the "General Definitions" section of this Benefits Chart
- Services needed because of your job. This includes programs to help you prepare for, find and/or keep a job (vocational rehabilitation).
- Any service or item not used for a dental need or purpose. This includes items and services for comfort, convenience or appearance.
- Services which are Elective, Investigative, experimental or not otherwise Clinically Accepted
- Services a Covered Person has no legal obligation to pay
- The portion of a billed Charge for an otherwise Covered Service by an Out-of-Network Provider, which is in excess of the Plan's maximum amount allowed
- Duplicate Charges or Charges for duplicate services
- Infection control, sterilization and waste disposal
- Sales tax
- Case presentations for treatment planning or behavioral management
- Post processing of image or image sets
- Caries risk assessment and documentation
- Non-dental administrative costs, including but not limited to:
  - Dental record preparation or mailing
  - Appointment cancellation fees
  - After hours appointment charges
  - Interest charges
- Charges for observation
- Charges for unspecified procedures
- The surgical placement of a dental implant body and all associated dental implant-related services to replace missing primary natural teeth or congenitally missing permanent natural teeth
- Services related to treatment planning and implant case planning
- Replacement of:
  - Any missing, lost or stolen dental or implant-supported prosthesis
  - Space maintainers
- Replacement or repair of Orthodontic appliances
- Services for Injury or Illness:
  - Arising out of an Injury in the course of employment and subject to workers' compensation or similar law
  - 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
  - For which benefits are payable under another policy of accident and health insurance, Medicare or any other governmental program